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SAJOUS'S
ANALYTIC CYCLOPEDIA
OF
PRACTICAL MEDICINE

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CONTENTS OF FIFTH VOLUME.

	PAGE		PAGE
Gas, Poisoning by (Coal or Illuminating Gas)	1	Glaucoma (<i>continued</i>)	
Illuminating Gas	1	Symptoms	24
Symptoms	2	Diagnosis	25
Acute Poisoning	2	Etiology	25
Automobile Gas Poisoning	3	Varieties	26
After-effects	3	Prognosis	26
Chronic Poisoning	5	Treatment	26
Treatment	6	Glycemia	28
Coal Gas from Stoves, Furnaces, etc., Poisoning by	9	Children	28
Gas of Warfare	9	Blood-sugar Tests	28
Symptoms	9	Clinical Applications	28
Pathology	10	Glycerin	28
Prophylaxis	10	Preparations and Doses	28
Treatment	10	Physiological Action	28
Gaultheria	11	Therapeutics	29
Preparations and Dose	11	Constipation	29
Physiological Action	11	Genitourinary Disorders	30
Poisoning by Gaultheria	12	Inflammatory and Septic Surgical Disorders	30
Treatment of Poisoning by Gaultheria	12	Glycosuria	32
Therapeutics	12	Definition	32
Gavage	12	Symptoms	32
Technique	12	Etiology	34
Gelatin	13	Treatment	38
Preparations and Dose	13	Goiter, or Struma; Bronchocele	39
Physiological Action	14	Etiology	39
Therapeutics	15	Functions of the Thyroid and Parathyroid	45
Gelsemium	16	Thyroiditis	46
Preparations and Dose	16	Symptoms	48
Physiological Action	17	Diagnosis	50
Poisoning by Gelsemium	17	Prognosis	50
Therapeutics	18	Treatment	50
Cerebral Disorders	18	Acute Strumitis	52
Spasmodic Disorders	18	Symptoms	52
Neuralgia	18	Diagnosis	53
Fevers	18	Prognosis	53
Skin Disorders	18	Treatment	53
Mydriasis	19	Congenital Goiter, or Goiter in the Newborn	54
General Paralysis, or Paresis. See Mental Diseases.		Symptoms	55
Gentian	19	Prognosis	55
Preparations and Doses	19	Treatment	55
Physiological Action	19	Chronic Goiters	50
Therapeutics	19	Diffuse Non-toxic Goiter: Hypothyroid Type	56
Genu Valgum and Varum. See Orthopedic Surgery.		Symptoms	57
German Measles. See Rubella.		Diagnosis	58
Gestation, Ectopic. See Pregnancy.		Prognosis	58
Ginger Inebriety. See Zingiberis.		Pathogenesis	58
Glands, or Farcy	19	Nodular Goiters	59
Definition	19	Non-toxic Type	59
Symptoms	19	Colloid Goiter	61
Diagnosis	21	Filrous Goiter	61
Treatment	23	Cystic Goiter	62
Glaucoma	24	Semimalignant or Malignant Types of Goiter	62

	PAGE		PAGE
Goiter, or Struma, Semimalignant or		Graves's Disease, Exophthalmic Goiter,	
Malignant types of Goiter (<i>continued</i>).		Basedow's Disease	106
Gouty Accessory Glands	62	Definition	106
Enlarged Goiter	62	Symptoms	107
Malignant Goiter	62	Enlargement of the Thyroid	108
Special Symptoms	63	Nervous Phenomena	111
Diagnosis	67	Cardiac Signs	111
Prognosis	68	Vasomotor Phenomena	113
Treatment of Chronic Goiter	68	Ocular Signs	114
Compensative Agents in Atoxic		Nutrition	115
Goiters	69	Miscellaneous Symptoms	118
Measures to Control Hyperthyroid-		Diagnosis	119
ism	72	Etiology	120
The X-ray Treatment	72	Primary Cause	125
Surgical Treatment	73	Pathology	130
Prophylaxis	73	Prognosis	131
Gold	73	Treatment	142
Physiological Action	73	Grindelia	142
Poisoning by Gold	74	Preparations and Doses	142
Treatment of Acute Poisoning by		Physiological Action	142
Gold	74	Therapeutics	142
Therapeutics	74	Guaiac	143
Genitourinary Disorders	74	Preparations and Doses	142
Phthisis	74	Physiological Action	143
Syphilis	74	Therapeutics	143
Effusions	74	Guaiacol	143
Gynecological Disorders	74	Preparations and Doses	144
Mental Disorders	74	Physiological Action	144
Inebriety	74	Poisoning by Guaiacol	144
Gonorrhea. See Urinary and Genital		Treatment of Guaiacol Poisoning ..	145
Systems, Surgical Diseases of.		Therapeutics	145
Gonorrheal Arthritis. See Rheumatism.		Pulmonary Disorders	145
Gonorrheal Ophthalmia. See Conjunc-		Surgical Tuberculosis	146
tiva, Diseases of.		Fever	146
Gonorrheal Rheumatism, See Rheuma-		Painful Disorders	147
tism.		Anesthesia	148
Gonorrheal Vaginitis. See Urinary and		Erysipelas	148
Genital Systems, Surgical		Guarana	149
Diseases of.		Preparations and Doses	149
Goundou (Anakhre, Henpue, Big-nose).	75	Physiological Action	149
Etiology and Pathology	75	Therapeutics	149
Treatment	75	Guinea-worm Disease. See Parasites,	
Gout	75	Diseases Due to.	
Synonyms	75	Gunshot Wounds of Abdomen. See Ab-	
Definitions	75	dominal Injuries.	
Symptoms	75	Gunshot Wounds of Brain. See Head	
Chronic Gout	78	and Brain, Diseases of.	
Irregular Gout	78	Gunshot Wounds of Head. See Head	
Diagnosis	81	and Brain, Diseases of.	
Etiology and Pathogeny	83	Gunshot Wounds of Stomach. See Ab-	
Pathology	90	dominal Injuries.	
Prognosis	93	Gypsum. See Calcium.	
Treatment	93		
Dietetic Treatment	94	Hair, Diseases of the	149
Open-air Exercise	96	Atrophy of the Hair	149
Treatment of Hereditary Gout ..	96	Physiological Atrophy	149
Treatment of the Acute Attack ..	97	Pathological Atrophy	149
Mineral Springs	101	Fragility of the Hair	150
Medicinal and Other Measures ..	102	Moniliform Hair	150
Internal or Retrocedent Gout	106	Etiology	150
Grafting, Skin-. See Skin-grafting.		Treatment	150
Grain and Vegetable Poisoning. See		Canities	151
Toxic Foods.		Synonyms	151
Grand Mal. See Epilepsy.		Etiology	151
Granular Lids. See Blepharitis.		Prognosis	151
Granuloma. See Mycosis Fungoides.		Treatment	151
		Hypertrophy of the Hair	152

	PAGE		PAGE
Hair, Diseases of the, Hypertrophy of the Hair (<i>continued</i>).		Head and Brain, Diseases of (<i>continued</i>).	
Synonyms	152	Diseases of the Skull	166
Partial Congenital Hypertrichosis.	152	Penetrating Wounds of the Skull and Brain	166
General Congenital Hypertrichosis	153	Symptoms and Diagnosis	166
Acquired Hypertrichosis	153	Prognosis	167
Partial Acquired Hypertrichosis .	153	Treatment	167
Etiology	153	Gunshot Wounds of the Head	168
Prognosis	154	Treatment	169
Treatment	154	Fungus, or Hernia, Cerebri	171
Epilation	154	Treatment	172
Shaving, Cutting, and Singeing ..	154	Pneumatocele	172
Depilatories	154	Microcephalus	172
Hydrogen Dioxide	154	Inflammation, Periostitis, Osteitis, Caries, and Necrosis	172
Pumice-stone	155	Symptoms	172
Electrolysis	155	Etiology	173
X-rays	156	Prognosis	173
Disorders of Secretion. See Seborrhea Sicca (Dandruff).		Treatment	173
Sycosis Non-parasitica	156	Hypertrophy of the Bones of the Skull	173
Symptoms	156	Atrophy of the Bones of the Skull .	173
Treatment	156	Tumors of the Skull	174
External or Local Treatment	157	Surgery of the Brain	175
Parasitic Disorders	158	Cerebral Localization	175
Tinea Favosa	158	Technique of Intracranial Surgery .	175
Synonyms	158	Precautions in Cerebral Surgery ..	184
Treatment	158	Surgery of the Lateral Ventricles ..	185
Tinea Trichophytina	159	Cerebral Concussion	186
Synonyms	159	Symptoms	186
Treatment	159	Prognosis	187
Pediculosis	160	Treatment	187
Synonyms	160	Cerebral Contusion and Laceration ...	187
Treatment	160	Symptoms	187
Neurotic Disorders	160	Pathology	188
Trichopathophobia	160	Prognosis	189
Voluntary Erection of the Hair	160	Treatment	189
Hamamelis	161	Subdural Hemorrhage	190
Preparations and Doses	161	Symptoms	190
Therapeutics	161	Etiology	190
In Hemorrhage	161	Pathology	190
As an Astringent	161	Treatment	190
Hammer Toe. See Orthopedic Surgery.		Cerebral Hemorrhage. See Cerebral Hemorrhage.	
Hand, Club-. See Orthopedic Surgery.		Compression of the Brain	190
Hanot's Cirrhosis. See Cirrhosis of the Liver.		Traumatic Intracranial Hemorrhage ..	191
Harelip. See Surgical Anaplasty, or Plastic Surgery.		Extradural Hemorrhage	192
Hashish. See Cannabis Indica.		Symptoms	192
Hay Fever. See Hyperesthetic Rhinitis.		Diagnosis	192
Head and Brain, Diseases of	162	Etiology	192
Diseases of the Scalp	162	Pathology	193
Contusions	162	Prognosis	193
Treatment	162	Treatment	193
Wounds of the Scalp	163	Abscess of Cerebrum and Cerebellum. See Cerebral Abscess.	
Treatment	163	Infective Sinus Thrombosis	194
Traumatic or Spurious Meningocele.	164	Symptoms	194
Abscess of the Scalp	164	Treatment	194
Treatment	164	Wounds of the Sinuses of the Brain .	195
Caput Succedaneum	164	Inflammation of the Brain and Meninges	195
Tumors	165	Pachymeningitis Externa	195
Sebaceous Tumor, or Wen	165	Pachymeningitis Interna	195
Treatment	165	Leptomeningitis	196
Horns	165	Foreign Bodies in the Brain	196
Warts and Moles	165	Tumors of the Brain	197
Fatty Tumors	165	Symptoms	197
Congenital Cysts, Fibromata	165		
Vascular Growths	165		

	PAGE		PAGE
Head and Brain, Diseases of, Tumors		Heart and Pericardium, Diseases of the,	
of the Brain (<i>continued</i>)		Myocarditis, Pathology (<i>continued</i>)	
Diagnosis	200	I. Acute Myocarditis	244
Tumors of Frontal Lobe	203	II. Chronic Myocarditis	246
Tumors in the Rolandic, or so-		Prognosis	247
called Motor, Region	204	I. Acute Myocarditis	247
Tumors of the Parietal Region	204	II. Chronic Fibroid Myocarditis	248
Tumors of the Occipital Lobe	204	Treatment	248
Tumors of the Temporosphenoidal		Hypertrophy of the Heart	251
Lobe	205	Definition	251
Tumors of the Corpus Callosum	205	Varieties	251
Tumors of the Great Ganglia	205	Symptoms	252
Tumors of the Corpora Quad-		Differential Diagnosis	254
rigemina	206	Etiology	254
Tumors of the Crus	206	Pathology	256
Tumors of the Pons	206	Prognosis	257
Tumors of the Medulla	207	Treatment	257
Tumors of the Cerebellum	207	Dilatation of the Heart	258
Tumors of the Base	208	Definition	258
Multiple Tumors	209	Varieties	258
Etiology	210	Symptoms	258
Predisposing Causes	210	Diagnosis	261
Sex	210	Etiology	263
Heredity	210	Prognosis	267
Exciting Causes	210	Treatment	269
Pathology	211	Pericardium, Diseases of the	273
Prognosis	212	Pericarditis	273
Treatment	213	Definition	273
Hydrocephalus	215	Symptoms	273
Definition	215	Diagnosis	277
Varieties	215	Etiology	279
I. Acute Hydrocephalus	216	Pathology	280
Definition	216	Prognosis	282
Symptoms	216	Treatment	282
Etiology	218	Chronic Adhesive Pericarditis (Ex-	
Pathology	220	ternal Pericarditis; Pleuro-	
Diagnosis	221	pericarditis; Mediastinoperi-	
Prognosis	222	carditis)	285
Treatment	222	Diagnosis	285
II. Chronic Hydrocephalus	224	Treatment	287
Definition	224	Hydropericardium	288
Varieties	224	Hemopericardium	288
Symptoms	224	Pneumopericardium	288
Etiology	225	Treatment	289
Pathology	226	Heart, Degenerative Disorders of the	289
Diagnosis	227	Definition	289
Treatment	227	Fatty Degeneration	289
Heart and Pericardium, Diseases of the.	229	Definition	289
General Diagnosis	229	Symptoms	289
Functional Efficiency Tests	229	Diagnosis	291
Irregularity of the Heart Beat	230	Etiology	293
Sinus Irregularity	230	Pathology	294
Heart Block	230	Prognosis	296
Premature Contractions	234	Treatment	296
Auricular Filbrillation	235	Fatty Overgrowth	298
Pulsus Alternans	238	Definition	298
Myocarditis	239	Symptoms	298
Definition	239	Differential Diagnosis	300
Varieties	239	Etiology	300
Symptoms	239	Pathology	300
I. Acute Myocarditis	239	Prognosis	301
II. Chronic Myocarditis	240	Treatment	301
Diagnosis	241	Prophylaxis	301
Etiology	242	Treatment of Fatty Overgrowth	302
I. Acute Myocarditis	242	Rupture of the Heart	303
II. Chronic Myocarditis	242	Symptoms	303
Pathology	244	Diagnosis	303

	PAGE		PAGE
Heart, Degenerative Disorders of the,		Hematology and Serum Reactions, Spec-	
Rupture of the Heart (<i>continued</i>).		fic Gravity (<i>continued</i>).	
Etiology	303	Hammerschlag's Method of Deter-	
Pathology	304	mining the Specific Gravity.	369
Prognosis	304	Estimation of the Percentage of	
Treatment	304	Hemoglobin	370
Brown Atrophy of the Heart	304	Tallqvist's Method	370
Calcareous Degeneration or Calcifica-		Gowers's Method	370
tion of the Heart	304	Sahli's Method	370
Amyloid Degeneration	305	Fleischl's Hemoglobinometer	370
Heart, Graphic Methods in the Examina-		Technique	371
tion of the	305	Color-index	373
Polygraphy	305	Total Volume of the Blood	373
Electrography and Electrocardiograms.	318	Viscosity of the Blood	373
The Phonoscope and Phonocardi-		Coagulation of the Blood. See Coagu-	
ography	326	lation Time of the Blood.	
Arrhythmias, Cardiac	327	Estimation of the Corpuscles	373
The Frequent Pulse	333	Diluting Fluids	373
The Infrequent Pulse	335	Technique	374
Heart, Palpitation of the	344	Counting the Erythrocytes	374
Symptoms	344	Calculation	375
Diagnosis	345	Counting of Leucocytes	375
Etiology	345	Differential Blood-count	376
Treatment	345	Method of Fixation	377
Heart, Irritable	346	Methods of Staining	377
Symptoms	346	Eosin and Methylene-blue Stain	377
Irritable Heart in Recruits	346	Technique	377
Etiology	347	Eosin-hematoxylin Stain	377
Pathology	348	Technique	378
Treatment	348	Wright's Stain	378
Heart, Uncommon Disorders of the	348	Technique	378
Tumors of the Heart	348	Effects	379
Symptoms	348	Giemsa's Stain	379
Treatment	349	Technique	379
Parasites of the Heart	349	Effects	379
Symptoms	349	Ehrlich's Triple Stain	379
Treatment	349	Technique	379
Aneurism of the Heart	349	Effects	379
Symptoms	350	Romanowsky's Polychrome Methyl-	
Treatment	351	ene-blue Stains	379
Movable, Mobile, or Wandering Heart		Jenner's Stain	379
Symptoms	351	Technique	380
Etiology	352	Effects	380
Treatment	352	Leishman's Stain	380
Heat Exhaustion and Thermic Fever	353	Technique	380
Heat Exhaustion	353	Effects	380
Symptoms	353	Examination of Blood-smears	380
Diagnosis	354	Technique	380
Etiology and Pathogenesis	354	Differential Leucocytic Count	380
Pathology	356	Polynuclear Leucocytes	380
Prophylaxis	356	Lymphocytes	380
Treatment	356	Large Mononuclear Leucocytes	380
Thermic Fever	356	Eosinophiles	381
Symptoms	356	Myelocytes	381
Etiology	359	Mast Cells	381
Pathology	360	Leucocytosis	381
Prognosis	362	Leucopenia	381
Prophylaxis	362	Variations of Volume	381
Treatment	362	Erythrocytes in a Stained Specimen	381
Hematology and Serum Reactions	368	Blood-picture in Different Diseases	382
Method of Obtaining a Specimen for		Opsonins and Opsonic Index	384
Examination	368	Serum Reactions	384
Color	368	The Widal Test	384
Taste	369	Technique	384
Odor	369	Occurrence of the Reaction	385
Reaction	369	The Wassermann Reaction	385
Specific Gravity	369	Hemolysis	385

	PAGE		PAGE
Hematology and Serum Reactions, Serum		Hemoglobinuria (<i>continued</i>)	
Reactions, The Wassermann Reaction		Treatment	411
Blood-corpuscle Emulsion	386	Hemopericardium. See Heart and Peri-	
Absorption of Complement	386	cardium, Diseases of.	
Antigen	386	Hemophilia	412
Illustration	387	Definition	412
Emery's Modification of the Wasser-		Symptoms	412
mann Reaction	387	Etiology and Pathogenesis	415
Collection of Blood	387	Pathology	417
Preparation of Antigen	387	Prognosis	417
Preparation of the Emulsion of		Treatment	417
Corpuscles	388	Hemoptysis. See Lungs, Diseases of.	
The Amboceptor	388	Hemorrhage. See various conditions in	
Apparatus	388	which it occurs and reme-	
Technique	388	diies under Hemorrhage in	
Interpretation of Results	388	Clinical Index.	
The Noguchi Butyric Acid Reaction.	389	Hemorrhagic Disorders of the Newborn.	
Technique	389	See Newborn, Disorders of,	
The Abderhalden Test	389	and Adrenal Hemorrhage.	
Technique of the Test	390	Hemorrhoids	424
Preparation of Placental or Other		Embryology	425
Tissues	390	External Hemorrhoids	427
Test for Impermeability of Dia-		Treatment of External Hemor-	
lyzing Thimbles to Albumin.	390	rroids	431
Test for Permeability of Thimbles		Internal Hemorrhoids	435
to Peptone	390	Treatment of Internal Hemorrhoids.	439
Optic Method	390	Operative Treatment	441
Other Applications of the Abder-		Henbane. See Hyoscyamus.	
halden Reaction	391	Henpue. See Goundou.	
Hematoporphyrinuria	392	Hereditary Ataxia. See Spinal Cord,	
Definition	392	Diseases of.	
Symptoms	392	Hernia	449
Etiology	393	Definition	449
Treatment	393	Varieties	449
Hematoxylon	394	Surgical Anatomy	450
Preparation and Dose	394	Etiology	451
Physiological Action	394	Reducible Hernia	454
Therapeutics	394	Diagnosis	454
Hematuria	394	Treatment	455
Definition	394	Trusses	455
Symptoms	394	Irreducible Hernia	457
Tests	394	Treatment	457
Heller's Test	394	Strangulated Hernia	458
The Guaiac Test (Almén-Schön-		Symptoms	459
lein)	395	Diagnosis	460
The Benzidin Test (Schumm)	395	Hydrocele of the Cord	461
Florence Test (for spermatic fluid)	395	Treatment	461
The Hemin Test (Teichmann)	395	Taxis	461
Spectral Analysis	395	Operation	464
Microscopic Examination	395	Incision	464
Etiology	396	Sac	464
Diagnosis	399	Division of Constriction	464
Urethral	399	Management of the Contents	464
Vesical	399	Intestinal Resection	467
Renal and Ureteral	399	Indications and Contraindications for	
Prognosis	400	the Radical Operation	468
Treatment	401	Children	468
Hemoglobinuria	402	Adults	468
Definition	402	Contraindications	469
Symptoms	402	Inguinal Hernia	469
Etiology	403	Radical Operation	469
Pathology	405	Results of Operation	474
Urine	405	Dangers and Complications of Radi-	
Blood	406	cal Operation	476
Paroxysms	410	Precautions	476
Diagnosis	410	Complications	478
Prognosis	411	Inguinal Hernia in the Female	479

	PAGE		PAGE
Hernia, Inguinal Hernia in the Female (continued)		Hiccough	532
Operative Treatment	480	Etiology and Pathogenesis	533
Femoral Hernia	481	Treatment	534
Diagnosis	481	Epidemic Hiccough	536
Treatment	482	Treatment	537
Reducible	482	Holocaine	537
Strangulated	482	Physiological Action	537
Radical Operation	482	Therapeutics	537
Umbilical Hernia	484	Homatropine	538
Varieties	484	Preparations and Dose	538
Congenital	485	Physiological Action	538
Treatment	485	Poisoning by Homatropine	538
Infantile	486	Treatment of Poisoning by Homatropine	539
Treatment	486	Therapeutics	540
Adult	487	Hydrastis	541
Treatment	487	Preparations and Dose	541
Ventral Hernia	489	Modes of Administration	542
Epigastric Hernia	490	Physiological Action	543
Cecal Hernia	491	Contraindications	544
Rare Forms of Hernia	492	Poisoning	545
Diaphragmatic Hernia	492	Therapeutics	545
Properitoneal, or Interstitial, Hernia	495	Hydroa. See Dermatitis (Dermatitis Herpetiformis).	
Lumbar Hernia	495	Hydrocele. See Penis and Testicles, Diseases and Injuries of.	
Hernia into the Foramen of Win- slow	496	Hydrocephalus. See Head and Brain, Surgical Disorders of.	
Ischiatic Hernia	496	Hydrochloric Acid	548
Perineal Hernia	496	Physiological Action	549
Obturator Hernia	497	Preparations and Dose	549
Heroin. See Opium.		Modes of Administration	550
Herpes Zoster and Herpes	498	Incompatibilities	550
Herpes Zoster (Shingles; Zona)	498	Contraindications	550
Definition	498	Poisoning	551
Symptoms	499	Treatment for Poisoning	553
Acute Specific or Spontaneous Zos- ter	500	Therapeutics	555
Regional Zoster	502	Hydrocyanic Acid	557
Zoster Atypicus Gangrenosus et Hystericus	503	Preparations and Dose	558
Diagnosis	504	Physiological Action	559
Etiology	504	Untoward Effects and Poisoning	560
Pathology	505	Treatment	562
Prognosis	507	Hydrogen Dioxide	565
Treatment	507	Preparation and Dose	565
Herpes (Herpes Febrilis)	510	Physiological Action	566
Definition	510	Therapeutics	568
Symptoms	510	Hydronephrosis. See Kidneys, Diseases of.	
Diagnosis	512	Hydropericardium. See Heart and Peri- cardium, Diseases of.	
Herpes Facialis (Fever-blisters)	512	Hydrophobia. See Rabies.	
Etiology	512	Hydropneumothorax. See Pleura, Dis- eases of.	
Pathology	513	Hydrosalpinx. See Ovaries and Tubes, Diseases of.	
Prognosis	514	Hydrotherapy. See Water.	
Treatment	515	Hydrothorax. See Pleura, Diseases of.	
Herpes Genitalis	516	Hyoscine. See Scopolia and Scopolamine.	
Symptoms	516	Hyoscyamus	575
Diagnosis	517	Preparations and Dose	576
Etiology	518	Physiological Action	577
Prognosis	518	Poisoning	578
Treatment	518	Treatment of Poisoning	578
Heterochylia. See Stomach, Diseases of.		Therapeutics	578
Hexamethylenamine	519	Hyperchlorhydria. See Stomach, Dis- eases of: Hyperacidity.	
Preparations and Dose	520	Hyperchylia. See Heterochylia, Index.	
Modes of Administration	520		
Contraindications	520		
Physiological Action	521		
Untoward Effects	525		
Therapeutic Uses	526		

	PAGE		PAGE
Hyperemesis Gravidarum. See Preg-		Ichthyosis (<i>continued</i>).	
nancy, Disorders of.		Pathology	642
Hyperemia, Bier's Treatment by	580	Etiology	642
Technique	581	Prognosis	642
Causes of Failure	582	Treatment	642
Advantages	582	Iceterus. See Liver, Diseases of.	
Indications for Use	582	Ileus. See Intestines, Diseases of: In-	
Surgical Principles Involved	582	testinal Obstruction.	
General Precautions	583	Impetigo Contagiosa	644
Elastic Bandage	583	Definition	644
Tension of Bandage	584	Symptoms	644
Precautions in the Use of the		Etiology	644
Bandage	584	Treatment	645
Retention of the Bandage	586	Impetigo Herpetiformis	646
Suction Glasses	587	Definition	646
Size of Glass	588	Symptoms	646
Degree of Suction	588	Etiology	646
Application	588	Treatment	647
Precautions	589	Impotence	647
After-treatment	589	Definition	647
Hot air	589	Varieties and Causes	647
Hot-air Douche	589	Treatment	647
The Hot-air Chamber	590	Incontinence of Urine. See Enuresis.	
Technique	590	Indicanuria	648
Indications	590	Definition	648
Special Therapeutics	591	Symptoms	648
Surgery	591	Heller's Test	648
Internal Disorders	594	Jaffé's Test	648
Ophthalmology, Otolaryngology, and Laryn-		Senator's Modified Jaffé's Test	648
gology	596	Daland's Test	648
Gynecology, Obstetrics, Urology, and		Holland's Test	648
Proctology	597	Obermayer's Test	648
Dermatology	599	Barberio's Test	649
Concomitant Medical Treatment	599	Etiology	649
Hyperesthetic Rhinitis	600	Treatment	653
Synonyms	600	Indicanemia	654
Definition	600	Infant Feeding and Nursing. See Nurs-	
Symptoms	600	ing and Artificial Feeding.	
Etiology and Pathogenesis	601	Infantile Paralysis. See Spinal Cord,	
Treatment	603	Diseases of.	
Climatic Treatment	608	Infantile Scorbutus	654
Surgical Treatment	608	Definition	654
Intraneural Injections of Alcohol	609	Symptoms	655
Hysteria	610	Complications	656
Symptoms	613	Diagnosis	656
Sensory Symptoms	613	Etiology	657
Motor Symptoms	616	Pathological Anatomy	658
Disorders of the Special Senses	619	Prognosis	658
Visceral Symptoms	621	Treatment	658
Miscellaneous Somatic Symptoms	622	Infiltration Anesthesia. See Coca.	
Psychic Symptoms	623	Influenza, or La Grippe	659
Diagnosis	627	Definition	659
Prognosis	627	Symptoms	659
Treatment	628	Clinical Types	661
Ichthyol	633	Complications and Sequelæ	662
Preparations and Dose	634	Respiratory Tract	662
Physiological Action	634	Nervous System	664
Untoward Action of Ichthyol	634	Circulatory System	664
Therapeutics	635	Special Sense Organs	665
Ichthyosis	640	Hemorrhagic Complications	665
Synonyms	641	Miscellaneous	666
Varieties	641	Diagnosis	666
Symptoms	641	Etiology	667
Ichthyosis Simplex	641	Pathology	668
Ichthyosis Hystrix	641	Prognosis	669
Diagnosis	642	Prophylaxis	669
		Treatment	671

	PAGE		PAGE
Infusions, Saline	678	Intestines, Diseases of the, Intestinal	
Intravenous Infusion	678	Catarrh, Symptoms (<i>continued</i>)	
Solutions	678	Colitis	707
Apparatus	679	Proctitis	707
Instruments	679	Chronic Form	707
Asepsis	679	War Enteritis or Trench Diar-	
Details of the Solution	679	rhea	708
Operative Site	680	Diagnosis	708
Preparation of the Patient	680	Etiology	708
Operative Technique	680	Morbid Anatomy	710
Intra-arterial Infusion	681	Prognosis	710
Apparatus	681	Treatment	711
Operative Site	682	Phlegmonous Enteritis	714
Technique	682	Croupous or Diphtherial Enteritis	714
Dawbarn's Method of Intra-arterial		Definition	714
Infusion	682	Symptoms	714
Technique	682	Etiology	715
Hypodermoclysis	683	Prognosis	715
Apparatus	683	Treatment	715
Asepsis	683	Celiac Disease	715
Details of the Solution	683	Definition	715
Injection Sites	683	Symptoms	715
Technique	683	Sprue or Psilosis	715
Internal Ear, Disorders of	684	Definition	715
Tuning-fork Tests	684	Symptoms	715
Syphilis	688	Diagnosis	716
Treatment	688	Etiology	716
Ménière's Disease	688	Morbid Anatomy	716
Treatment	690	Prognosis	717
Occupation-deafness	690	Treatment	717
Tinnitus	691	Hill Diarrhea	718
Intertrigo, Erythema Intertrigo, or Chaf-		Definition	718
ing	691	Symptoms	718
Definition	691	Etiology	718
Symptoms	691	Pathology	718
Diagnosis	692	Treatment	718
Etiology	692	Cholera Morbus	718
Treatment	692	Synonyms	718
Intestinal Parasites. See Parasites, Dis-		Definition	718
eases Due to.		Symptoms	718
Intestines, Diseases of the	694	Diagnosis	719
Normal and Pathological Physiology	694	Etiology	719
Intestinal Neuroses	697	Pathology	719
A. Motor Disturbance	697	Prognosis	719
Nervous Diarrhea	697	Treatment	719
Intestinal Spasm	698	Cholera Asiatica	719
Intestinal Paralysis	698	Definition	719
Treatment	698	Historical Note	720
B. Sensory Disorders	698	Symptoms	720
Treatment	699	Complications and Sequelæ	723
C. Secretory Disorders	699	Diagnosis	723
Mucous Colitis	699	Etiology	724
Synonyms	699	Pathology	726
Definition	699	Prognosis	727
Symptoms	700	Prophylaxis	727
Diagnosis	702	Treatment	729
Etiology	702	Intestinal Infarction	734
Pathology	703	Intestinal Ulcers	737
Prognosis	703	Duodenal Ulcer	737
Treatment	703	Definition	737
Intestinal Catarrh	706	Symptoms	737
Synonyms	706	Diagnosis	740
Definition	706	Etiology	745
Symptoms	706	Pathology	746
Acute Forms	706	Prognosis	747
Duodenitis	707	Treatment	747
Jejunitis and Ileitis	707	Simple Follicular Ulcers	749

	PAGE		PAGE
Intestines, Diseases of the (<i>continued</i>).		Intestines, Diseases of the (<i>continued</i>).	
Stercoral Ulcers	750	Visceroptosis	770
Treatment	750	Synonyms	770
Ulcerative Colitis	750	Definition	770
Symptoms	750	Symptoms	771
Diagnosis	750	Diagnosis	774
Prognosis	751	Etiology	775
Treatment	751	Mechanism	776
Intestinal Tuberculosis	752	Pathology	778
Etiology	752	Prognosis	778
Pathology	753	Treatment	779
Symptoms	754	Intestinal Stasis; Coprostasis	784
Diagnosis	754	Definition	784
Treatment	755	Symptoms	784
Intestinal Sand	756	Diagnosis	786
Intestinal Calculi	757	Treatment	788
Intestinal Obstruction	757	Hirschsprung's Disease or Congenital	
Definition	757	Megacolon	791
Symptoms	757	Definition	791
Acute Obstruction	757	Symptoms	791
Chronic Obstruction	759	Diagnosis	792
Diagnosis	759	Pathology	792
Etiology	762	Treatment	793
Strangulation	762	Intravenous Injection Technique. See	
Intussusception	763	Infusions, Saline.	
Volvulus	764	Intubation of the Larynx	793
Tumors	765	Indication	794
Strictures	765	Intubation in Diphtheria	795
Corprostasis; Gall-stones; Entero-		Technique	796
liths; Foreign Bodies	765	After-treatment of Intubated Cases ...	803
Intestinal Paresis. Postoperative		Obstruction of Tube	804
Obstruction, or Paralytic		Prolonged Use of Tube	806
Ileus	766	Modification of O'Dwyer's Instru-	
Pathology	767	ments	809
Prognosis	768	Comparative Value of Intubation	810
Treatment	768		

SAJOUS'S

ANALYTIC CYCLOPEDIA

of PRACTICAL MEDICINE

G

GAS, POISONING BY (Coal or Illuminating Gas).—Carbon gases are sufficiently toxic when inhaled to cause many deaths yearly. One of the illuminating gases, acetylene, a product of calcium carbide, was considered in Vol. I (see article ACETYLENE); those to be reviewed under the present head will be the ordinary "burning" or "illuminating" gases, and coal gas derived from partly consumed combustibles, coal, wood, charcoal, etc.—all of which owe their toxicity to carbon monoxide. The mephitic gases which so frequently prove fatal in mines will be described under MINE ASPHYXIAS.

ILLUMINATING GAS.

The toxicity of ordinary illuminating gas depends mainly upon the proportion of carbon monoxide (CO) it contains. Thus, while gas obtained by the distillation of coal contains about 8 per cent. of carbon monoxide, water gas, generated through the action of steam on highly heated coke or coal, contains over 30 per cent. As a result, the introduction of the modern water gas has greatly increased the mortality ratio of illuminating gas, even taking into account the vast increase in the public use of

this commodity, and including among deaths only those recorded as due to accidental or intentional (suicidal) causes. How many deaths are indirectly traceable to gas which leaks into the inadequately aired dwellings is unknown; they are doubtless many.

The coma, tissue degenerations, and death after several days, from carbon monoxide poisoning, are not due to retention of the gas, but to injury to the brain and other organs by insufficiency of oxygen while the patient was breathing the gas. Henderson (Jour. Amer. Med. Assoc., Aug. 19, 1916).

The view that red corpuscles once choked with carbon monoxide are dead is not tenable. All they need is oxygen under sufficient tension to displace the carbon monoxide. M. Nicloux (Presse méd., Mar. 15, 1917).

Pure carbon monoxide is one of the most insidious poisons known. It is without odor, the penetrating odor of illuminating gas being due to other relatively harmless constituents. It may be inhaled, therefore, in considerable amount without being noticed.

Poisoning by odorless illuminating gas in 12 persons sleeping in the same house. They suffered from intractable vomiting, violent headache, and lassitude. As none of the guests who slept out of the house were

affected, and three persons who slept in the basement of the house and did not share in the festivities were included among the sufferers, the food and drink of the party were clearly not to blame. The patients recovered during the day, but on the second night their condition was similar to, but even worse than on the first night. They recovered as soon as they slept elsewhere, and three volunteers who slept in the house developed the same symptoms. The mystery was solved when, several yards from the house, a leak was detected in a gas pipe as it passed over a water pipe. The escaping gas was deodorized by the earth through which it filtered, and its course was through the old cesspool, and up a ventilation shaft which opened under the house, and thus enabled the gas to invade all the rooms. E. Thomsen (Clinical Jour., from Petersburger med. Zeit., p. 30, 1913).

Having an affinity for hemoglobin three hundred times as great as oxygen, carbon monoxide attaches itself firmly to this pigment and deprives the blood of its oxygenizing property.

SYMPTOMS.—The effects of illuminating gas may be of two kinds: *acute*, such as those due to the accidental or purposeful inhalation of large quantities of gas within a short time, and *chronic*, such as due to the slow but continuous inhalation of gas from leaky pipes, or the CO-laden air of gas or smelting works, coke or charcoal furnaces, etc.

ACUTE POISONING.—In the majority of instances acute intoxication is due to escaping gas owing to imperfect closure of a stopcock or to the inhalation of gas with suicidal intent. The patient is usually found unconscious with flaccid limbs, or in a condition of spastic stiffness or rigidity if the poisoning is very deep. The face is flushed or very red—the blood

itself becoming cherry red—and in severe poisoning cyanotic, though in some cases there is pallor.

In every case of poisoning by the oxide of carbon the blood suffers characteristic changes. The blood takes a special cherry-red color which cannot be confounded with any other, so that on the dissecting table the special poison is detected by means of spectroscopic examinations. The oxide of carbon, *in vivo* as *in vitro*, substitutes the oxygen of the oxy-hemoglobin, leading to a formation of carboöxyhemoglobin of cherry-red color. This special color of the blood, which already appears extensively in all the visible mucous membranes, is more apparent in the serous membranes and especially in the brain. De Dominicis (Semaine méd., Feb. 20, 1913).

The respiration is shallow, though regular, slow, and often stertorous. The pulse is slow, becoming weaker as the toxemia increases. The pupils are small and react feebly to the light; there may be fibrillary muscular contractions or twitchings, tremor or spasm with muscular cramps and trismus. Occasionally tetanus or violent convulsions are witnessed, with paralysis of the sphincters. There is no suffering, however. In unfavorable cases the coma deepens and the patient passes away without marked preagonal phenomena, excepting in some instances a marked rise of temperature, which, on the whole, had previously shown but a small rise. The presence of coma does not, however, always mean a fatal ending. In favorable cases the morbid signs slowly disappear owing to the gradual elimination of carbon monoxide from the blood.

In a personal case the carbonic oxide had disappeared from the blood, presumably in consequence of the ap-

plication of artificial respiration. This case is of importance, because it is the first on record in which it was proved that in three hours practically the whole of the carbonic oxide had been eliminated from the blood. When one exposed to carbonic oxide is found still breathing, and placed in normal air, the carbonic oxide is gradually eliminated from the blood, so that after some hours it has completely disappeared. The eliminating force is the affinity of the oxygen for the hemoglobin, and the higher the percentage of oxygen the quicker the elimination. Lorrain Smith (*Brit. Med. Jour.*, April 1, 1899).

Owing to transient defective ventilation, a number of the women employed in the ironing room were taken acutely sick. One of the women showed no symptoms at the time, but complained of nausea on the way home and two days later of pains in head, neck, and back, with occasionally vertigo and syncope. The heart action was weak, the pulse fast and irregular, the extremities cold. She remained for ten weeks in the hospital. The author found her pulse 125 two years after the injury, the patient still complaining of headache and internal restlessness which prevented her from working for long at a time. Lewin (*Berl. klin. Woch.*, Oct. 28, 1907).

AUTOMOBILE GAS POISONING.—The noxious fumes and gases emitted by automobiles have become a source of danger mainly to the automobilist himself who uses small closed cars, and when in small garages, with doors and windows closed, the engines are allowed to run for testing and other purposes. Many deaths have occurred from this cause in this and other countries. The fumes may be the result of excessive lubrication or of the formation of an imperfect explosive mixture due to the use of low grade gasoline when the air supply is deficient. The ex-

haust gases may then contain an excess of carbon monoxide, as much as one-fifth. Haldane found that 0.05 per cent. of carbon monoxide in air may produce symptoms of poisoning; 0.1 per cent. will cause headache and palpitation, while 0.2 per cent. is absolutely dangerous. Carbon monoxide is invisible and merely detectable by the symptoms it produces if inhaled. It is lighter than air, and so when emitted from a moving car will ascend and quickly become diluted. It is only when, through a leak in the exhaust pipe that it escapes into the surrounding air. This mixture when inhaled causes asphyctic phenomena which may prove fatal in the same manner as illuminating gas.

AFTER-EFFECTS.—Sometimes, where the carbon-monoxide intoxication has been profound, the recovery is only apparent. Soon, the patient begins to suffer from headache and weakness, amnesia, mental torpor, drowsiness, and shows contracted pupils, though they may react to light, more or less marked fibrillary contraction, and finally death from asthenia without apparent suffering.

In a case in which fatal recurrence occurred three days after apparent recovery, a careful examination of the central nervous system showed numerous small hemorrhages throughout the pia mater, especially that of the spinal cord. There were small hemorrhages in the white and gray substance of the spinal cord, some of these being surrounded by softened patches. Small thrombi were found in the left optic thalamus, and fatty degeneration of the endothelium of the small vessels throughout the central nervous system. There were chromolytic and atrophic changes in the large motor cells of the spinal cord, with partial thicken-

ing of the pia mater of the brain, and degenerations of the nerve-fibers of the central and peripheral system. G. Hedren (Nordiskt Med. Arkiv, Bd. xxxv, 3:2 Foljden, Bd. ii, p. 10, 1903).

Case which apparently recovered in two days; later, symptoms of serious organic brain lesions developing and ending fatally, forty days after the accident. Necropsy revealed areas of softening in the lenticular nuclei and microscopic cerebral lesions. McConnell and Spiller (Trans. Amer. Med. Assoc.; N. Y. Med. Jour., June 8, 1912).

In other cases the after-effects, though not entailing death, may be very severe, especially in the direction of the cerebrospinal system and the mind. The various nervous sequelæ may include cerebral hemorrhage, hemiplegia, paraplegia, partial paralyses, various paresthesias, hyperesthesia, anesthesia, multiple sclerosis, hysteria, chorea, tetany, and disorders of sight and hearing. The mental morbid phenomena witnessed include amnesia, melancholia, mental torpor, mental confusion, temporary mania, dementia, aphasia, and feeble-mindedness.

The nervous symptoms are both varied and inconstant. Convulsions occur in about 7 per cent. of all cases and muscular rigidity in a slightly larger proportion. The reflex and pupil symptoms show great variability. The coma bears no definite relation to the intensity or duration of the fever. Coma lasting four or five days is not invariably fatal. In the series of 90 comatose cases only 17 cases, or 18.8 per cent., were fatal. Pneumonia is an infrequent complication, and in a large percentage of fatal cases the cause of death may be referred to cerebral lesions, such as congestion of the meninges and brain substance, hemorrhage of the cerebral capillaries, or hemorrhage into and softening of the internal capsule,

lenticular nucleus, and adjacent structures. Thompson (Med. Record, July 9, 1904).

Report of a case of asphyxiation from coal gas. The patient after a prolonged convalescence left the hospital after a stay of fourteen weeks. He reported incidents of early life and childhood usually well, recognized his old acquaintances and repeated their names, but had no recollection of anything that transpired from thirty-six to forty-eight hours prior to the accident nor what happened afterward. He died suddenly three weeks after his discharge. Sanger Brown (Jour. Amer. Med. Assoc., April 28, 1906).

Microscopically, very definite lesions of the brain can be demonstrated. The cortical vessels are dilated, but in the subcortical white matter the changes are more marked—viz., congestion, hemorrhage, and the rupture of small vessels. Sometimes this rupture is into the brain substance, sometimes into the perivascular sheath. The capillary endothelium appears swollen and shows fatty changes. The most marked changes are seen in the white matter of the centrum ovale, especially in the occipital lobe. F. W. Mott ("Arch. of Neurol.," Claybury Asylum, vol. iii, p. 246).

How does the CO act on the nervous system? There are two principal hypotheses: (a) That all the symptoms are produced by the anoxemia due to the action of the CO on the oxyhemoglobin of the red cells, with resulting deprivation of oxygen to the nervous tissue and vascular changes—hemorrhages, thromboses, and degenerations; (b) Le Dosseur's theory that the CO, having once saturated the red cells, becomes dissolved in the serum and attaches itself to the nerve-cells and has a direct toxic effect on them.

Which, if either, of these two views is the correct one remains to be proved. A. J. Hall (Lancet, May 28, 1910).

Case of illuminating-gas poisoning followed some weeks after apparent recovery by an attack of confusional insanity, somewhat resembling the Korsakoff syndrome. The symptoms disappeared in about six weeks' time, and the patient was discharged as completely recovered four months after admission to the asylum. The frequency of gas poisoning has increased since the general use of "water gas" for illuminating purposes. Mary O'Malley (*Jour. Amer. Med. Assoc.*, Oct 26, 1912).

Thrombi capable of causing gangrene may also be formed under the influence of carbon monoxide. A striking peculiarity is a persistent and high leucocyte count, which rises, according to W. G. Thompson, in many cases above 18,000 and in fatal cases as high as 50,000. A high degree of leucocytosis is an unfavorable prognostic sign.

Case of poisoning by burning gas, resulting in gangrene of both legs. The illuminating gas which was the cause was found to contain 7 per cent. of carbon monoxide. The case, the writer thinks, demonstrates that the effects of carbon-monoxide poisoning are more far-reaching than has been generally supposed and that, though recovery may apparently be complete in a few days or even a few weeks, startling and irreparable damage may have been done to the tissues. In this case diabetic gangrene, chemical gangrene, senile gangrene, and gangrene from exposure to extremes of temperature can all be excluded. Thrombotic and embolic gangrene can also be excluded. McLean (*Jour. Amer. Med. Assoc.*, May 20, 1911).

The writers observed a patient, a man, in whom, about 3 weeks after poisoning with illuminating gas, there developed gangrene of the foot and phlegmasia alba dolens. The case ended in recovery. Laignel-Lavastine and Alajouanine (*Bull. de la Soc. Méd. des Hôp.*, Apr. 15, 1921).

CHRONIC POISONING.—In this form, due to the prolonged inhalation of small quantities of carbon monoxide from a leaky pipe, smelting works, etc., headache (apt to be worse in the morning and very severe if the proportion of gas in the air is anything but very small), vertigo, tinnitus aurium, nausea, ephemeral rises of temperature, especially during the afternoon, may suggest malaria and even typhoid fever. As a rule, however, the symptoms are vague and misleading, suggesting anemia. Mild frontal headache (worse in the morning), tinnitus, vertigo with anorexia and a bad taste in the mouth, frequent indigestion, colicky pains, constipation, and lassitude constitute the average syndromes observed.

Chronic carbon-monoxide poisoning occurs more frequently than is imagined, and is undoubtedly responsible for many obscure conditions which occur in the practice of every physician and often remain an unsolved puzzle. The large increase in the use of gas for cooking purposes will not lessen the evil, and we should be prepared to make a diagnosis of this toxic condition as readily as we do of the acute form. A more extensive use of the spectroscope in daily clinical work should be made, as skill with the instrument is easily acquired. That chronic poisoning by illuminating gas should occur seems inexcusable if proper precautions are taken to see that gas-fixtures are impermeable to gas. Servants should be apprised of the danger of not turning off the valves of gas-ranges completely. T. J. Yarrow (*Amer. Medicine*, Aug. 30, 1902).

The case histories of 35 persons who for years during their working hours had to breathe air containing from 1 per 10,000 to 1000 carbon monoxide. In the course of years they all developed nervous, digestive and general symptoms varying in in-

tensity, but most severe in the work-rooms with the highest proportion of the impurity in the air. The syndrome was alike in each case, commencing with headache and occasional dizziness, then lassitude, loss of appetite, insomnia varied with nightmares followed, and neuralgias, intense or slight, transient or fixed, unilateral or bilateral, intercostal, subcostal, abdominal, and especially in the lumbar and sacral region. The digestive disturbances were those characteristic of hyperchlorhydria; 12 of the patients had intermittent albuminuria, 3 transient glycosuria, and all grew thin and pale, some being so sallow as to suggest cancer. Some epileptics were among the patients and their previously rare seizures became so frequent that institutional measures were soon necessary. All the symptoms reached their acme in winter, when the defective furnaces and heaters were at work, but became attenuated during the spring and disappeared entirely during the summer vacation at first. In later years they became more continuous with lesser remissions. In 3 of the youngest patients the syndrome was diagnosed as pretuberculosis and they were sent out of town, returning much improved. In another case incipient tabes was diagnosed on account of the asthenia, and psychic and neuralgic disturbances. A few other patients presented signs of congestion in the bladder and prostate. Gautier also reported the case of a physician who paid no attention to a little gas escaping in his office for a few weeks, until he developed a condition of extreme weakness, neurasthenia, and "the blues" requiring three months' vacation to regain his normal poise. Gautier himself had attacks of faintness at night for more than a month after exposure to carbon monoxide for a short time during an operation in the open air. The syncope was so severe each time that he felt he was dying, and his weakness was extreme. Carbon-monoxide poisoning may prove fatal after a long interval,

as in Bourdon's case, in which a sudden fatal syncope followed several weeks after the acute monoxide poisoning from which the man had apparently recovered. The speakers all emphasized the insidious danger from slightly defective hot-air radiators and gas-jets, and the emanations from gas-ranges, etc. Courmont, Morel, and Mouriquand (Jour. Amer. Med. Assoc., from Bull. de l'Acad. de Méd., Dec. 20, 1910).

TREATMENT.—In the *acute* form of illuminating-gas poisoning, as recently emphasized by McCombs (Amer. Jour. of Med. Sci., Oct., 1912), the essential treatment, in all stages, consists in the inhalation of **oxygen**, under pressure whenever possible, and in sufficient quantities to displace as much as possible the carbon monoxide combined with the hemoglobin.

In the *first stage*, *i.e.*, that preceding the loss of consciousness, **fresh air** combined with mild stimulation, such as **aromatic spirit of ammonia**, should be practised. In this stage the nausea, vomiting, and headache are the most troublesome symptoms. The greater part of the gastric symptoms will be relieved by some effervescing salt, the patients feeling much better after eructating or vomiting. **Effervescing phosphate of sodium** may be used. The headache usually persists for twenty-four or forty-eight hours and may be relieved by any of the drugs used for this condition. Violent exertion is to be avoided, as collapse is a danger; men who have become aggressively delirious have collapsed.

In the *second stage*, in which the patient is unconscious but breathing, it may be necessary, if the respirations are not stertorous, to assist the respiratory action. The Howard **artificial respiration** method (com-

pression of the lower part of the chest in rhythm with expiration, explained in the article on DROWNING) has been found efficient. **Oxygen** must be administered, preferably under pressure.

Various mechanical devices for administering artificial respiration and supplying oxygen have been tried, but until lately all were unsatisfactory. At present the "**pulmotor**," described in the article on OXYGEN, is being used.

Stimulants, such as **camphor**, **caffeine**, **digitalis**, and **strychnine**, should be freely administered hypodermically. As there are several instances in which the persons have collapsed when taken out into cold air, it is always best to start treatment in a warm room. An important adjunct is **massaging of the muscles** after aërating the lungs, the resulting increase in the general circulation often promptly restoring the normal oxygen balance.

The above methods are usually followed by prompt recovery. If they are not successful, **venesection**, with the introduction of normal **salt solution**, should be employed. In 2 cases McCombs saw this method followed by rapid and complete recovery, although there was mental confusion for some time. It should be employed when the patients are in fairly good condition when rescued, that is, with a fair pulse, stertorous respirations, unconsciousness, and no immediate signs of collapse.

It is difficult to appreciate the value of **saline solution** in poisoning by oxide of carbon. This has been shown by the experiments of Moromarcò in 1892, which were made after the proposal of Kühne that saline injections should be used in all forms

of grave poisoning. Cases have been reported by Schreiber, Bergman, and Fraentzel of the advantage of this method of treatment. Brodier (*Méd. moderne*, June 13, 1896).

In a series of 6 cases of gas poisoning, the writer's treatment consisted chiefly in giving from 1 to 2 pints (500 to 1000 c.c.) of a hot, sterile, modified **Ringer solution** by subpectoral infusion. This fluid was made up in distilled water as follows: **calcium chloride**, 0.25 Gm. (4 grains) per liter (quart), 0.025 per cent.; **potassium chloride**, 0.083 Gm. (1½ grains) per liter, 0.0083 per cent.; **sodium chloride**, 7.5 Gm. (2 drams) per liter, 0.075 per cent.

The results of this method of treatment were very encouraging: 4 of the cases, 2 of them serious, all overcome under the same conditions and at the same time, were brought into the hospital together. Of these, 1, treated by **saline infusion**, was able to go home the next day, while the other severe case, treated with oxygen, etc., remained unconscious for thirty-six hours, finally dying three weeks later of pneumonia.

The second case reported was the most severe that the author ever saw, was utterly prostrated and was apparently moribund on admission. It seemed to be a useless task to try to resuscitate her, and yet she was out of danger within six hours. H. W. Dana (*Boston Med. and Surg. Jour.*, May 27, 1909).

The patient should be taken from the room and into **fresh air**. The tongue should be extracted from the mouth and so retained by means of a hemostat, improvised gag, or tongue extractor. If necessary, **artificial respiration** should be begun at once. The patient should be removed without delay to an institution or physician's office, where immediate **phlebotomy** should be performed. A pint to a pint and a half of blood should be removed, and simultaneously a quart of normal **saline solution** transfused into the median basilic or cephalic vein of the

opposite forearm. **Venesection** can be repeated two hours after the first bloodletting, if the patient be not doing well. Saline solution should be given subcutaneously every two hours in quantities of one pint, or by the rectum continuously. Saline solution diminishes toxemia, lessens the tendency to edema of the lungs, increases the affinity of red cells for oxygen, and stimulates the circulatory system. At the outset the patient should be given by hypodermic injection **ether** 30 minims (2 c.c.), **atropine** $\frac{1}{100}$ grain (0.00065 Gm.), and **adrenalin** 30 minims (2 c.c.). Nitroglycerin and vasodilators in general should be avoided. Jones (Amer. Jour. Med. Sci., Jan., 1909).

In carbon monoxide poisoning the **prolonged inhalation of pure oxygen** as soon as possible will insure resurrection. In animals deeply intoxicated practically all the carbon monoxide had disappeared from the blood by the end of an hour of continuous oxygen inhalation. M. Nicloux (Presse méd., Mar. 15, 1917).

The "pulmotor" has increased the chances of recovery, but, should it fail, the best method is the direct **transfusion of blood** as practised by Crile. (See under **INFUSION**, this volume.)

Experiments made by the writers upon 15 dogs showed the following results: Of cases in which the heart had stopped: (1) Blood transfusion saved 3 out of 6; (2) intravenous saline injection, none saved; (3) simple manipulation saved none. Of cases in which the heart had almost stopped: (1) Blood transfusion saved 4, 1 died; (2) intravenous saline injection saved none. The authors' conclusions are: (1) **Blood transfusion** seems to be of greater therapeutic value than other measures. (2) Transfusion should be commenced as soon as the heart stops beating to insure the best results. It will not be efficacious after the heart stops finally. Crile and Lenhart (Amer. Jour. Med. Sci., Oct., 1907).

In the *third stage*, with the patient not breathing and unconscious, **artificial respiration, oxygen, stimulation, and heat** are imperative. **Transfusion** is indicated. The Schäfer, or "prone-pressure," method of artificial respiration is the best to use. (The various methods of artificial respiration are described under **DROWNING**, Vol. IV.)

Artificial respiration has been maintained for six hours, with subsequent recovery of the patient.

If the above methods of treatment are carried out and the patient is not dead when discovered, practically all cases should recover in forty-eight to seventy-two hours from the immediate effects of the gas. The great difficulty in treatment has been the failure of both laymen and physicians to realize that inhalation of **oxygen** under pressure, combined with **venesection** or **blood transfusion** in severe poisoning, will save practically all cases.

Personal case. The patient was well covered with blankets and surrounded by **hot-water bottles**, and was given $\frac{1}{30}$ grain (0.0022 Gm.) of **strychnine** hypodermically. The median basilic vein of the right arm was **opened** and 300 c.c. ($\frac{3}{8}$ pint) of **blood allowed to flow**, after which an **intravenous transfusion** of 1200 c.c. (2 $\frac{1}{2}$ pints) of a 0.7 normal **saline solution** was given. Inhalations of **oxygen** were also given. Three hours later the face was somewhat reddened and the patient was perspiring, but was still comatose. Temperature was 100° F. (37.8° C.), pulse 136, respiration 32; 2 grains (0.13 Gm.) of **caffeine sodium benzoate** were given hypodermically every four hours. After another three hours the patient responded somewhat to **external stimulation**, but was still comatose. Temperature was 101° F. (38.3° C.), pulse 120, respiration 36. At the end of an-

other three hours the condition was about the same. On the second day the face and hands of the patient had assumed a distinct cherry hue. The man was drowsy, responded very slowly to questions, after answering which he immediately sank into sleep. The treatment consisted of the administration of **strychnine**, $\frac{1}{30}$ grain (0.0022 Gm.), and **caffeine sodium benzoate**, 2 grains, given hypodermically every 4 hours. Nourishment consisted of 6 ounces of milk and 12 ounces of water. On the third day consciousness returned. Ravine (Jour. Amer. Med. Assoc., June 3, 1911).

COAL GAS FROM STOVES, FURNACES, ETC., POISONING BY.

Although the odor of this gas differs totally from that of illuminating gas, the pathogenic cause is the same: carbon monoxide. Illuminating gas, as previously stated, owes its odor to its other constituents, which include benzene. The proportion of CO being greater, however, in stove or heater coal gas, its toxicity is correspondingly greater.

Case of a man and 2 horses, all killed by carbon-monoxide poisoning. They had slept in a stable which was in the basement of a house and the symptoms of the poisoning were very distinct. It appeared that the gas had been generated in a stove in a small room which communicated with a passage leading to the stable, had passed along this passage and killed the man and the 2 horses in the lowest part. The generation of the gas was favored in that the fire in the stove was kept low. K. Wolf (Münch. med. Woch., Feb. 10, 1903).

The **symptoms and treatment** of coal-gas poisoning do not differ from those of intoxication by illuminating gas described in the foregoing pages.

During carbon monoxide asphyxia there is vigorous hyperpnea, followed by a diminished production of CO₂.

Due to deficiency of CO₂ in the blood, asphyxiated animals, when restored to pure air, exhibit for one-half hour or more great depression of breathing. Tissue asphyxia thus continues, although the body is surrounded by fresh air. This post-gassing period is of critical importance. While oxygen inhalation during this period had only a slight effect, not being adequately inspired, that of CO₂ diluted with air immediately increased breathing and thus hastened the elimination of carbon monoxide. But the inhalation of **oxygen plus CO₂** proved far more effective than either gas alone, the augmented breathing allowing the oxygen to effect a rapid displacement of carbon monoxide from the blood. Henderson and Haggard (Jour. Pharm. and Exper. Therap., Aug., 1920).

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GAS OF WARFARE.—SYMPTOMS.—Pneumotoxic warfare or "gassing," consists in the use of vapor derived from some toxic or irritating substance, chlorine, prussic acid, etc., to kill or disable the enemy, first used by the Germans in the recent war. There are said to be, according to J. C. McWalter (Clin. Jour., May 10, 1916), 43 different gases capable of being used. They may be discharged from reservoirs, as drift gas, or in an explosive or asphyxiating shell, as shell gas. The drift gas is mostly chlorine, forming a heavy greenish-yellow cloud, and often causing sudden death from edema of the glottis. Bromine is said also to be present, causing the stupor which often follows, and extreme lacrymation. Sulphurous acid and the hydrogen compounds of arsenic and phosphorus are also used.

When a man is "gassed" 3 stages are observed: (1) That in which he dies within the first couple of hours. His face is greenish-yellow, due to shock, edema of the glottis, and poisoning by the gases. (2) The second stage is described by the soldier as "dryland drowning." There is edema of the lungs, a yellow, albuminous, chlorinous fluid fills the air passages, clogs the alveoli, and suddenly oozes into the

trachea with such copiousness that fluid may drop from the nose and throat. There is a violent shedding of epithelial cells, followed by acute emphysema, air escaping into the interstitial tissues, even in the neck and upper part of the chest. The patient suffers the torments of asphyxiation and toxemia alike in every anguished breath. Respirations may be 60 to 80 a minute and very shallow. Vomiting is frequent and copious, with intolerable pain in the epigastrium. The fluid is often thin and yellow, sometimes streaked with blood. In the earlier stage headache is almost constant. Of those arriving at the clearing stations, the mortality was probably about 7 per cent. Probably not more than 2 per cent. of those reaching the base hospitals succumbed, but a considerable percentage of asthmatic lung trouble, etc., persisted for months. (3) These are the cases seen in the home hospitals. There may be headache, bronchitis, gastric catarrh, pleuritis, and rapid respiration. Some show stupor and weakness of the legs. Exertion may bring on an asthmatoïd seizure, the roof of the mouth may be dry and glazed, and the tongue coated with a dry fur. There are also suggestions of collapse of the cerebrospinal system.

Another type of gas used now by the enemy is a vesicating irritant to the skin and mucous membrane, the so-called "mustard gas," while the others produce death from inhalation. The vesicating gas as described by R. G. LeConte (U. S. Naval and Med. Bull., July, 1918) is most commonly dichlorethyl sulphide (does not contain mustard), and its irritating effect is not immediately noticeable. It pervades and penetrates the clothing, and the longer this is worn the more intense will be the burning. The handling of shell fragments, of the clothes, and any other article that has come in contact with this gas will burn the hands unless they are protected by leather or rubber gloves. When treatment is started early its effects are evanescent even on the conjunctivæ, and the patient will return to duty in a few days. Where treatment is delayed, the resultant burns may incapacitate for some weeks. The scrotum, inner surface of the thigh, and armpits are the portions of the body most severely burned.

PATHOLOGY.—Mott (Brit. Med. Jour., May 19, 1917) examined the brains of 2 cases of gas poisoning. The whole of the white matter was studded with small dark spots. These were due to hemorrhages, but microscopic examination showed conditions not found in carbon monoxide or other forms of gas poisoning. The red blood-corpuscles were largely broken up, and the hemoglobin converted into dark chocolate colored pigment granules, which filled the capillaries, arterioles and venules of the white matter. This was possibly methemoglobin.

Examination of the blood in 44 cases by Miller and Rainy (Lancet, May 26, 1917) showed that when symptoms persist, there is an increase in the number of lymphocytes, relative and absolute. In slight cases this may not be beyond the normal limits. If the percentage of lymphocytes approaches that of the polymorphonuclears, the case is still suffering from the effects of the gassing, provided there is no other complicating disease.

PROPHYLAXIS.—A mask or respirator saturated with a solution capable of absorbing the gas is generally employed. McWalter (*ibid.*) suggests that the following might, on emergency, be effective. A couple of folds of lint, saturated with a solution containing 10 per cent. of **sodium bicarbonate**, and 20 per cent. of **sodium hyposulphite** in water, and placed over the mouth and nose, seem to absorb chlorine, arseniuretted hydrogen, or other poisonous gas thoroughly.

In the Italian army, according to P. Sisto (Riforma medica, Nov. 20, 1916), the masks have layers of gauze impregnated with aqueous or glycerinated solution of **potassium carbonate**, **sodium carbonate**, or **sodium hyposulphite** which fix chlorine, bromine, and acid gases in general.

TREATMENT.—There is an overwhelming sensation of fatigue, which induces the man to lie down. He must, according to McWalter (*ibid.*), be kept moving. The best treatment is **strychnine** and **atropine** hypodermically, together with **alcohol** hypodermically or per rectum, if it cannot be taken orally.

Sisto (Riforma med., Nov. 20, 1916) states that in the Italian army the treatment consists of inhalations of **oxygen** and

subcutaneous injections of **camphorated oil** and **ether**, **hypodermoclysis**, and **venesection**. **Blood-letting** is best done with the lancet, on account of the ready coagulability of the blood. **Digitalis** was of great service in the graver cases.

Hebblethwaite (Brit. Med. Jour., July 22, 1916) treated 30 cases of chlorine gas poisoning by **venesection**. It is indicated in all except the cyanotic cases, or where cardiac failure is paramount. The amount withdrawn ranges from 15 to 25 ounces, according to the patient. The results are relief of cyanosis, pulmonary congestion, and acute headache, while promoting sleep.

Boudreau (Jour. de méd. de Bordeaux, Sept., 1916) recommends **tincture of iodine** internally as a potent means to hasten restoration of living tissues. A drop or 2 of the French tincture is added to each glass of water, milk, tea or other beverage taken during the day, 5 to 7 doses being thus taken. The dose is increased by 1 drop each day until some of his patients reached hundreds of drops a day and kept this up a long time.

Sajous has recommended that **adrenalin** be used in these cases, inasmuch as it supplies the blood with the substance which takes up the oxygen of the air and becomes the active respiratory agent of the hemoglobin molecule. **Hypodermoclysis** in small quantities with adrenalin injected slowly into the rubber pipe carrying the saline commends itself as a useful procedure, and is advised for both acute and chronic cases.

For "mustard gas" poisoning treatment is started by making a change of clothing. At the advanced hospital patients are at once stripped and washed with **lime water**, the eyes bathed with it, and the mouth, nose, and pharynx treated with the same solution.

Lime water is specific and neutralizes the gas immediately.

Poisoning with chlorine or mustard gas causes chronic digestive disturbances oftener than poisoning by pallete or benzyl bromide. Such disturbances are met with in about 6 per cent. of the chlorine and mustard gas cases. M. Loeper (Bull. de l'Acad. de méd., Mar. 2, 1920).

Investigations made to determine the minimum concentration of mustard gas that will produce effects on the unprotected eye of man showed that the eyes are the structures of the body most sensitive to mustard gas. Concentrations of 0.0005 milligram of mustard gas to the litre of air—1 part in 10 millions—will produce visible eye reactions from less than 1 hour of exposure in individuals whose skin resistance is relatively high. C. I. Reed (Jour. Pharm. and Exper. Therap., Mar., 1920). S.

GAULTHERIA.—The *Gaultheria procumbens*, or wintergreen, is a small, shrub-like evergreen plant, bearing a small, red berry (called teaberry, checkerberry, partridge-berry, boxberry, or deerberry), which is edible. It is indigenous to the woods of the United States, from the extreme north down to the Carolinas. The leaves alone were used for the two preparations formerly in the U. S. P. By distillation of the leaves a volatile oil (*oleum gaultheriæ*, U. S. P. VIII) results. This oil is of a light-straw color, which becomes darker on exposure to the air. It possesses a peculiar penetrating odor, a sweetish, pungent, aromatic taste, and a slight acid reaction. It contains a hydrocarbon (*gaultherin*) and an acid (*methsalicylic acid*); consists almost entirely of pure methyl salicylate (96 per cent.). It is soluble in alcohol, ether, chloroform, and carbon disulphide. Besides having medicinal virtues, it may be used as a flavor. Methyl salicylate has been officially recognized as a complete substitute for oil of *gaultheria*.

PREPARATIONS AND DOSE.—*Oleum gaultheriæ*, U. S. P. VIII (oil of *gaultheria*), the dose of which is from 5 to 30 minims (0.3 to 2 c.c.), best given in emulsion or dropped on a lump of sugar, or in capsules. The latter, however, are apt to cause gastric disturbance by bringing the oil in contact with the gastric mucosa.

Spiritus gaultheriæ U. S. P. VIII (spirit of *gaultheria*), may be given in doses of from 10 to 20 minims (0.65 to 1.3 c.c.).

PHYSIOLOGICAL ACTION.—The physiological action of *gaultheria* is almost identical with that of *salicylic acid*

(*q.v.*); in small doses it is a stimulant and carminative. In larger doses it is an antiseptic, antipyretic, antirheumatic, and analgesic. In therapeutic doses the oil is entirely decomposed in the system, although in tonic doses it may escape in part unchanged by the urine.

POISONING BY GAULTHERIA.—

In slightly toxic doses there is produced a marked tinnitus aurium, nausea, vomiting, and rapid pulse. One ounce of the oil has proved fatal. In this case the principal symptoms were profound diaphoresis, pain in the head and abdomen, purging; frequent, painful, and at last involuntary micturition; with convulsions, tonic spasms, dilated pupils, lessening arterial pressure, abolition of sight and hearing, rapid respiration, depression of the heart's action, and finally death by respiratory failure in fifteen hours. In children 1 dram (4 c.c.) has sufficed to produce death. In a case reported by H. C. Dodge, the stomach was evacuated within fifteen minutes, and the child seemed relieved and slept for some hours. He then showed dyspnea, corroded tongue and lips, and diuresis. Convulsions, collapse, and death followed.

Treatment of Poisoning by Gaultheria.—

The stomach should be evacuated by means of an hypodermic injection of **apomorphine** ($\frac{1}{10}$ to $\frac{1}{8}$ grain—0.006 to 0.01 c.c.), or if conscious, by any available emetic. Cardiac and respiratory stimulants (**ether**, **caffeine**, **strychnine**) are then indicated, using **artificial respiration**. Relieve convulsions or spasms by the hypodermic administration of **morphine**.

THERAPEUTICS.—The therapeutic uses of gaultheria are similar to those of salicylic acid. The oil is employed principally in the treatment of **acute articular rheumatism** in doses of 5 to 30 minims (0.3 to 2 c.c.), in capsules, in emulsion, or dropped on sugar, three or more times daily, as the case may require. Lint saturated with the oil, wrapped around the part affected, and covered with a piece of thin rubber cloth or rubber tissue to prevent evaporation, may be used, as suggested by Lannois and Limousin, in cases of **acute** and **chronic rheumatic joints**. The salicylates are more efficient in the various forms of rheumatism, and should be given preference.

Oil of gaultheria tried in 122 cases of **arthritis** of various kinds, with uniformly encouraging results. When combined with suitable balneotherapy, the patients were cured more rapidly than when treated with baths alone. It is administered in capsules, each capsule containing 18 drops of the oil. Two capsules are given at a time, beginning when retiring, two one hour later, and two more during the night. E. von Rottenbiller (*Klinisch-therap. Woch.*, May 20, 1900). M.

GAVAGE.—This procedure, which has received considerable notoriety in the political campaign of the so-called "militant suffragists" in England, under the title of "forced feeding," consists in supplying food to the stomach through the intermediary of a stomach-tube. It is usually carried out through the mouth, but if the patient struggles or opposes the measures, as is the case with infants and "suffragettes," the tube is introduced through the nose.

Gavage is resorted to in many conditions—after operations about the mouth or throat, **intubation**, **tracheotomy**, **laryngotomy**, etc.—which would be compromised by the process of deglutition of foodstuffs; and also when, as in the course of various acute diseases, **typhoid fever**, **scarlet fever**, **diphtheria**, etc., the patient will refuse nourishment, or, again, when the patient is unconscious, as after an attack of **apoplexy**. It is also useful in conditions such as **laryngeal tuberculosis**, **cancer of the esophagus**, **esophageal paralysis**, etc., when either through the excessive pain caused or mechanical impossibility the patient cannot swallow even soft foods or liquids. It is of considerable use in immature infants, or the normal processes of nursing or feeding, as in cleft palate, cannot be carried out.

TECHNIQUE.—The ordinary stomach-tube, provided with a soft catheter (No. 10 American for children) and a glass funnel of the capacity of about 1 pint, will serve for all purposes. But strict asepsis is necessary, particularly when the tube is used in infectious cases such as diphtheria, scarlet fever, and the like. It should be

carefully washed out and then immersed in an antiseptic solution, or, preferably, boiled.

Prior to insertion the tube or catheter should be immersed in warm water and lubricated with glycerin. In willing adults it is readily passed down the esophagus, on either side of the epiglottis, down the pyriform sinus. When opposition is encountered, as in the insane, children, etc., the patient should previously be wrapped, including arms and legs, in a strong sheet or blanket and the tube introduced gently through either nostril. It will glide down the esophagus if well lubricated with glycerin. There may be temporary resistance at first, on reaching the isthmus, but by waiting an instant the causative spasm of the isthmian muscles will cease and the tube will slip downward. The tube should not be forced down or introduced below the cardiac end of the esophagus to any extent; in infants the length of the latter canal is about seven inches from the gums; in a child 2 years old, nine inches; in one of 10 years, eleven inches; in an adult, about sixteen inches. The appropriate length of tube to be used should be marked on the tube and the mark taken as the limit when the tube is introduced.

Where the required amount of food has been administered by pouring it, in small quantities at a time, into the funnel, the tube is withdrawn, pinching it as this is being done, to avoid the spilling of food into the pharynx or larynx. The patient should remain quiet in the semirecumbent position for some time after the procedure. When gastric catarrh is present it is very advantageous to wash out the stomach with warm water fifteen, to twenty minutes before resorting to gavage. S.

GELATIN is obtained from tendons, bones, hides, etc., of cattle and other animals. The crushed bone, hide shreds, etc., used for the purpose are first macerated and subjected to the action of lime or caustic soda in pits for two or three weeks. This dissolves the blood and saponifies the fats. The excess of lime or soda is then removed by washing, and the balance steamed to remove the gelatin, but an excess of heat is avoided. Sulphurous acid

is used to bleach the gelatin. When of sufficient strength, the gelatin is allowed to harden in molds or on slabs, and is ultimately dried in sheets on wire netting (Anderson).

PREPARATIONS AND DOSE.—The above mode of preparation, which is that of the commercial gelatin, obviously suggests the danger of contamination when used by injection. The truth of this has been demonstrated by the occurrence of numerous cases of fatal tetanus when the use of gelatin was first introduced for the treatment of hemorrhage, hemophilia, aneurism, etc. The gelatin was found to contain bacilli or spores. This persisted until perfect sterilization of the gelatin had been obtained, and we now have such at our disposal. Whenever used, therefore, for therapeutic purposes, **gelatina sterilisata**, now on the market, *should alone be employed*.

In regard to the strength of the solution, there seems to be considerable divergence of opinion. Generally, Merck's 10 per cent. solution of gelatina sterilisata is employed for subcutaneous injection, preferably in saline solution at the body temperature. The preferred situations for injections are between the shoulder-blades, under the breast, and on the outer side of the thigh.

Gelatin is the best hemostatic we possess, and is indicated in all severe bleedings where the source of the bleeding cannot be reached. Its combination with physiological salt solution, to replace the blood lost, is desirable in many cases. The amount of gelatin used should be at least 2 Gm. (30 grains). The most suitable preparation on the market is the 10 per cent. sterilized solution made by Merck. Only this should be used for subcutaneous injection, to avoid infection. The internal administration is to be preferred to the subcutaneous, where a sterilized solution cannot be had, owing to the danger of tetanus. A. Heddaeus (Münch. med. Woch., Feb. 4, 1908).

The gelatin solution is warmed to the body temperature, and 10 c.c. (2½ drams) are injected by means of a

syringe that has previously been well warmed. The injection is made into the subcutaneous tissues of the thigh, the skin being raised for the purpose. The same quantity is injected into the corresponding part of the opposite thigh. The punctures are covered with iodoform gauze and adhesive plaster. The tumor-like swellings of the subcutaneous connective tissue are treated with warm, moist compresses to aid absorption. This part of the body appears more suitable for the injection than the intraclavicular region, recommended by others, or both sides of the back, for the patient usually lies on his back, and the injections are least inconvenient in the thighs. W. Engelmann (Deut. med. Woch., Nu. 24, 1910).

The styptic action of sterilized gelatin is equally marked when it is administered by the mouth. It becomes converted in the stomach into a substance known as *gelatose*, which is transmissible through the gastrointestinal mucous membranes.

The increase of coagulability of the blood is also produced when gelatin is given by the mouth. Dogs were experimented upon, and in 1 case the femoral artery was cut across after the animal had been fed upon gelatin digested by artificial gastric juice. Bleeding ceased entirely in one minute fifty seconds. As the author remarks, it must not be forgotten that dogs never bleed so freely as does man. In every case there was a distinct shortening of the time required for complete coagulation of the blood. In eight observations the average time for clotting before the administration of *gelatose* was three minutes forty-one seconds; after the gelatin had been taken, this time was reduced to one minute thirty-two seconds. Hence it follows that stomach digestion of gelatin does not destroy its coagulative properties, that gelatin is capable of absorption, and that, therefore, the administration of gelatin by the mouth in the treatment of hemorrhages is not

an entirely futile proceeding. H. C. Wood (Amer. Medicine, May 3, 1902).

PHYSIOLOGICAL ACTION.—In 1896 Dastre and Floresco found that the intravenous injection of a gelatin solution in animals caused the blood to coagulate more rapidly when withdrawn from the vessels, and that it antagonized the power of peptone in hindering coagulation of the blood. Camus and Gley explained the result by attributing it to the acidity of the gelatin solution; but Floresco, while admitting that the acid reaction has a certain influence, showed that neutralized gelatin is also active. Bauermeister explained it by an action in the leucocytes which are killed by the gelatin, and in dying produce the ferment which brings about blood coagulation. When injected subcutaneously the same effect is observed, but there is still much uncertainty regarding the rate and method of its absorption.

A 2 per cent. solution of gelatin in physiological saline solution, when injected hypodermically, is absorbed in proportion to the amount injected. Whether such injections hasten the coagulation of the blood seems a little doubtful, for in the animals experimented upon purely physiological variations in the time of coagulation (as estimated by comparison of the time of formation of the first layer of coagulum) were observed equal to those which seem to follow the gelatin injections. Endovenous injections undoubtedly hasten coagulation. The density of the blood is also modified by the injections. In 3 cases of **aneurism**, in which hypodermic injections were given, decided improvement occurred, although no definite cure. For example, in the first case (one of thoracic aneurism) 1250 c.c. (2½ pints) of a 2 per cent. gelatin solution were injected in seven doses in the course of two months, with the result that the area of dullness was diminished, the tumor reduced (as tested by radioscapy), the epigastric pulsation disappeared, and the fremitus and double murmur to the right of the

sternum disappeared. Mariani (Il Policlinico, Jan., 1901).

The explanations put forward regarding the coagulating action of gelatin are unsatisfactory. The action may be due to the presence of inorganic constituents, such as calcium. With this object in view the writer analyzed several specimens of gelatin, and proved calcium constantly present in the proportion of about 0.6 per cent. Consequently a patient in an injection of 100 c.c. ($3\frac{1}{2}$ ounces) of a 5 per cent. gelatin solution receives $\frac{1}{66}$ gr. (0.001 Gm.) of calcium, probably in an easily absorbable form. Zibell (Münch. med. Woch., Nu. 43, 1901).

While the manner in which the coagulability of the blood is increased by gelatin is still obscure, it is probable that, as recently shown by Renard (Russkii Wratsch, No. 11, 1910), this action is due to an increase in the proportion of fibrin ferment in the blood.

By injecting 25 to 40 c.c. (6 to 10 drams) of 10 per cent. Merck's sterilized gelatin, the author obtained an increase in the coagulability of the blood that appeared on an average two to four hours after the application. At first it lasted only a quarter to half a minute, though from hour to hour it increased until ten to twelve hours after the injection it had reached its maximum. The degree of increased coagulability varied in different experiments. The time of clotting usually declined by fully 66 per cent., and in isolated cases it declined as much as 85 per cent. This effect continued unabated for several hours. An explanation of the action of gelatin is still difficult to give. Grau (Deut. med. Woch., Nu. 27, 1910).

THERAPEUTICS.—Gelatin as previously stated is mainly used in all hemorrhagic conditions. Paul Carnot in 1898 treated a severe case of **epistaxis** in a hemophilic by the injection of a 5 per cent. gelatin solution into the nostril, and the bleeding stopped almost at once. A second similar case was successfully

treated by means of a 10 per cent. solution. Many other forms of **external hemorrhages** were controlled in the same way or by means of tampons soaked in the solution. Siredey used it locally in **metrorrhagia**, bleeding from **hemorrhoids**, **epistaxis**; and successful cases have been reported by others. Its action is rapid and lasting, and without danger. Poliakov reports a case of **hemorrhage from gastric ulcer** in which 6 ounces (180 c.c.) of a 10 per cent. solution given thrice in twenty-four hours stopped the bleeding. **Bleeding from the lower bowel** was also controlled by injections. Hemoptysis did not seem to be much benefited by its internal administration. Nogues treated cases of **hemorrhage from the bladder** by injections of gelatin solution into the organ. The viscus was first thoroughly washed out with boric lotion, and then several small injections of a 5 per cent. gelatin solution were given, and again washed out, the bladder ultimately being left partially filled with it.

The *subcutaneous injection* of gelatin to stop hemorrhage was first used by Lancereaux and Paulesco. Cases of **hemoptysis**, hemophilic bleedings, and **bleeding from toxemia** can all be treated in this way. Several physicians have used with success a 2 per cent. solution in hemoptysis, in **bleeding from the bowel in typhoid**, and in **hemophilia**. As a rule, about 6 ounces (180 c.c.) are injected daily for several days in succession. In obstinate hemorrhage after various operations it also proved effective, and likewise controlled several cases of bleeding of **purpura hemorrhagica**. The subcutaneous use of gelatin is indicated in all hemorrhages, such as **hematemesis**, **metrorrhagia**, **melenae neonatorum**, the **purpuric forms of the infectious diseases**, and is contraindicated only in acute nephritis and parenchymatous renal hemorrhage.

The writer used hypodermic injections of gelatin in 3 desperate cases of bleeding. In the first case the patient was a bleeder who had **uncontrollable hemorrhage** after extraction of a tooth. It recurred on the third day, and was treated by local application of a 10 per cent. gelatin solution and injection of 100 Gm. ($3\frac{1}{2}$ ounces) of a 2 per cent. gelatin saline solu-

tion into the upper part of the thigh. This caused the bleeding to cease in a few hours. The injection was repeated next day. There was no recurrence of hemorrhage. Injection area became painful, and after ten days an abscess was opened and found to contain sterile pus. In the second case a bleeder had epistaxis lasting for seven days. All ordinary treatment was useless, so 10 per cent. gelatin was used locally, and subcutaneously into each thigh, 100 gr. ($7\frac{1}{2}$ Gm.) of 2 per cent. gelatin in saline solution were injected. There was albuminuria. The bleeding ceased. Next day patient developed pneumonia, and died in a few days. The last case was one of **recurrent epistaxis**, which was cured in three-quarters of an hour by subcutaneous use of 100 gr. ($7\frac{1}{2}$ Gm.) of 2 per cent. solution. It is clear that, thus used, gelatin is not an altogether innocent drug. In the first 2 cases albuminuria and rise of temperature were noted, while in 1 case it proved so irritating that an abscess formed. Gebele (Münch. med. Woch., Nu. 24, 1901).

In secondary **postoperative hemorrhage** the writer has obtained very good results with injections of gelatin solution. He therefore recommends in such cases that the bleeding wound should not be reopened immediately, but that a gelatin injection be given. By this means not only is the hemorrhage checked, but the patient will be enabled to recover, and the prospect of a successful result from the operation will be improved after a few hours have passed. Chaput (Münch. med. Woch., S. 317, 1909).

Good results from the use of gelatin in a case of **purpura hemorrhagica** with epistaxis, hemorrhage from the mouth, and melena were observed by the writer. Marfan (Münch. med. Woch., S. 317, 1909).

In **melena neonatorum** Vassmer (1910) obtained a mortality of but 8.8 per cent. in 34 cases, as compared to a previous mortality of 61.3 per cent. in 31 cases treated without gelatin.

Carnot recently advocated the use of gelatin by the mouth in lieu of agar-agar for the treatment of **constipation**. It takes up water readily and renders the feces more bulky and softer. Powdered or cut-up gelatin is given in doses of 2 to 5 Gm. (30 to 75 grains) during meals.

A new method of treating **catarrh of the large intestine** was tried by the writer in a number of cases. It consists in pouring hot gelatin solution into the bowel. His reports deal almost exclusively with severe forms of chronic catarrh of the large intestine, forming a transition to dysentery. An indication of the value of gelatin is provided by the fact that in the case described by the author the usual treatment had been used without success. The daily introduction of 40 to 80 Gm. ($1\frac{1}{3}$ to $2\frac{2}{3}$ ounces) of sterile gelatin in 400 to 500 c.c. ($\frac{1}{2}$ to 1 pint) of Carlsbad water at 45° C. led in almost every case to a striking improvement which showed itself not only in the subsidence of the subjective symptoms, and in a reduction in the number of stools and an alteration in their consistency, but also occasionally in the functional activity of the bowel and in the endoscopic examination. The introduction into the bowel of hot gelatin solution is quite free from danger and produces no secondary effects. L. v. Aldor (Therap. Monatshefte, Nu. 4, S. 171, 1910). S.

GELSEMIUM.—Gelsemium, U. S. P., or yellow-jasmine, is the dried rhizome and rootlets of the *Gelsemium sempervirens*, a climbing plant indigenous to the southern United States. The odor is aromatic and oppressive and the taste bitter. Gelsemium contains a resinoid, gelsemin; an acid, gelsemic or gelseminic acid, and an alkaloid, gelseminine, which occurs in small, white, microscopic crystals, which have no odor, but an intensely persistent, bitter taste. The alkaloid forms salts which are freely soluble in water. The alkaloid itself is soluble in alcohol, ether, and chloroform.

PREPARATIONS AND DOSE.—The *fluidextractum gelsemii*, U. S. P. (extract of

gelsemium), the dose of which is 2 to 5 minims (0.12 to 0.3 c.c.).

The *tinctura gelsemii* (tincture of gelsemium), the dose of which is 4 to 12 minims (0.24 to 0.75 c.c.).

Gelseminina (gelseminine), $\frac{1}{20}$ to $\frac{1}{30}$ grain (0.0005 to 0.002 Gm.), should only be used with the greatest care.

Remedial properties of gelsemium depend upon two alkaloids which have been found in the rhizome and roots, namely, gelsemine and gelseminine. The former, gelsemine, resembles strychnine in its action, but beyond this very little is known about it.

Gelsemium usually depends upon gelseminine for its effect, this being present in quantities that overbalance the gelsemine. Gelseminine does not increase arterial tension, but rather lessens it. It is one of the most certain and powerful depressors of the motor nerves. It is indicated in all cases where there is hyperemia of the brain or the cord; in fact, in all cerebrospinal inflammations and hyperemias, but not in passive congestions. Reading the surface indications, the eclectics recommended gelsemium when the face is flushed, the eye bright, the pupil contracted, the head hot, and the patient presents restlessness and excitability. It is most effective in the earlier stages of fever with sthenic manifestations. In small doses it is likewise of value in many forms of nervous irritability. The dose of gelseminine ordinarily employed for an adult is $\frac{1}{250}$ grain (0.00025 Gm.), and this may be repeated every ten, fifteen, or thirty minutes as the occasion requires, until drooping of the eyelids and weakness of the lower jaw indicate a full and beginning toxic action of the drug. W. F. Waugh (Amer. Jour. Clin. Med., Dec., 1907).

PHYSIOLOGICAL ACTION.—Gelsemium depresses the cardiac action and the general circulation. It depresses the vagal, respiratory, and heat centers. These phenomena are produced in some even by small (10 drop) doses of the tincture, for

example, as observed by Muenich. In therapeutic doses gelsemium does not produce gastric irritation. The active principle diffuses into the blood with great facility. In moderate doses gelsemium causes a feeling of languor and calm, slowing of the heart-action, drooping of the eyelids, dilatation of the pupils, and some feebleness of muscular movement. In larger doses gelsemium causes vertigo, amblyopia, diplopia, paralysis of the muscles of the upper eyelid so that it cannot be raised, dilated pupil, labored respiration, slow and feeble action of the heart, great muscular weakness, and diminished sensibility to pain and touch. These effects follow in a half-hour after stomach ingestion and last two or three hours, when they subside.

Gelsemium is a powerful though ephemeral mydriatic when a solution is applied. It produces this effect by paralyzing the peripheral oculomotor nerves.

POISONING BY GELSEMIUM.

—When lethal doses are taken the physiological effects are intensified. A staggering gait is followed by a loss of muscular power and a sense of general numbness over the whole body. The eyelids close; the muscles become paralyzed, those of the jaw first; the pupils become widely dilated and fail to respond to the stimulus of light; vision is lost. The lower jaw drops, the tongue becomes paralyzed, and speech is lost. The respirations are irregular, shallow, and labored. The heart action and pulse become feeble and weak and then intermittent. The skin is generally covered with a profuse perspiration. The body heat is markedly lowered. Internal strabismus is apt to occur (paralysis of sixth pair); the face becomes pinched and anxious. Death occurs from centric respiratory failure.

Case of poisoning observed from the tincture of gelsemium administered to a woman aged 40 suffering from severe neuralgia; 10-minim (0.6 c.c.) doses every two or three hours were given the first day, and, no relief being obtained, 20-minim (1.25 c.c.) doses were administered for another twenty-four hours. Symptoms of poisoning then came on, consisting in a total loss of power in the

tongue, alteration in vision, with widely dilated pupils, and uncertain power of the muscles of the hand and arm. The patient was perfectly conscious. Then $\frac{1}{120}$ grain (0.0005 Gm.) of strychnine was injected, and in ten minutes a change for the better was noted. The vision was not perfectly restored for some hours. Edward Jepson (Brit. Med. Jour., Sept. 19, 1891).

Though consciousness is present for a long time, drowsiness or stupor finally appears.

Treatment of Gelsemium Poisoning.—The evacuation of the stomach by means of **emetics** or the **stomach-pump** should be followed by the use of cardiac stimulants (**ammonia** and **digitalis**), the application of **artificial respiration**, **external heat**, and the hypodermic administration of **atropine** and **strychnine** to stimulate the respiratory center. The maintenance of the **horizontal posture** is desirable. **Faradization** and the **hot** and **cold douche** are to be borne in mind.

THERAPEUTICS.—Exaltation of sensory or motor function is an indication for the use of gelsemium. Small doses should be used at first, until the susceptibility of the patient is ascertained. Ptosis, or drooping of the upper eyelid, gives warning that the physiological action of the drug is present.

Cerebral Disorders.—In **mania** with great motor excitement and wakefulness, Bartholow considered gelsemium superior to conium.

To produce the best results, sufficiently large doses should be given to produce definite physiological effects: Dilated pupil, drooping of the eyelids, and a feeling of languor. The excitement incident to **acute alcoholism**, simple **wakefulness**, and the **insomnia** following too great mental or physical activity are often benefited by gelsemium. In **meningitis** and **cerebrospinal meningitis**, Bartholow recommended the fluidextract in 5-minim (0.6 c.c.) doses every two hours to maintain the physiological effect. According to Garland, there is no drug equal to gelsemium in those crises of **cerebral excitement** which were formerly combated by **asafetida** and **valerian**.

Spasmodic Disorders.—In **spasmodic cough**, with little or no secretion from the bronchial tubes, gelsemium generally gives prompt relief.

The drug has been recommended as a useful remedy in the spasmodic stage of **pertussis**, the **nervous cough of hysteria**, the nagging **cough of phthisis** with scanty secretion, and in reflex cough from irritation of the laryngeal nerves. **Hysterical spasms** are controlled by gelsemium, the patient becoming calm and tractable.

Chorea, **laryngismus stridulus**, and **spasmodic dysuria** have yielded to gelsemium in many cases. **Torticollis** and localized **facial spasm** may be relieved by the drug.

Neuralgias.—**Facial**, **intercostal**, **ovarian**, and other **neuralgias** have proved amenable to gelsemium. Large doses are sometimes necessary, relief not appearing until the characteristic drooping of the eye, dilated pupil, and muscular languor appear. From 5 to 20 minims (0.3 to 1.25 c.c.) of the fluidextract every three hours may be required. Gelsemium is considered by Jackson the remedy *par excellence* for neuralgias of the lower jaw and the acute congestive stage of cold in the head.

Fevers.—Excellent results have been claimed from the use of gelsemium in **pneumonia** and **pleurisy**. In the former it diminished respiratory activity, affording rest to the inflamed organ; it allays cough, lessens stasis of the pulmonary capillaries, and lowers the temperature. Bartholow used to give 5 to 10 minims (0.3 to 0.6 c.c.) of the fluidextract every two hours to sustain the effect. The same method is employed in **pleurisy**. It is also regarded as a valuable agent to abort **acute coryza**.

Bilious and **malarial fevers** have been treated by the administration of gelsemium, especially in the Southern States, where it has enjoyed the reputation of a specific. Its utility is probably due to its antipyretic action.

Skin Disorders.—Bulkley has recommended gelsemium for the relief of itching in **eczema**: 3 to 10 drops of the tincture are given and increased every half-hour until the physiological effects are observed or the patient relieved. Not more than 1 dram (4 Gm.) should be given in all within two hours.

Mydriasis.—Gelseminine in watery solution (1 to 64) has been recommended by Tweedy for use as a mydriatic. He believes it equal to atropine. The effects disappear more rapidly. Its use is not without danger; it has not come into general favor. W.

GENERAL PARALYSIS, OR PARESIS. See MENTAL DISEASES.

GENTIAN.—Gentian (Gentiana, U. S. P.) is the root of the *Gentiana lutea*, or yellow gentian, indigenous to Europe. The root contains a bitter principle, *gentianin*, and an acid, *gentianic* or *gentisic acid*.

PREPARATIONS AND DOSES.—The *tinctura gentianæ composita*, U. S. P. (compound tincture); dose, 1 to 2 drams (4 to 8 c.c.); composed of gentian, bitter orange peel, and cardamom.

The *fluidextractum gentianæ*, U. S. P. (fluidextract of gentian); dose, 30 minims to 1 dram (2 to 4 c.c.).

The *extractum gentianæ*, U. S. P. (solid extract of gentian); dose, 1 to 8 grains (0.065 to 0.5 Gm.).

PHYSIOLOGICAL ACTION.—Owing mainly to its extreme bitterness and to the reflex stimulation through the sensory end-organs it produces, gentian increases the flow of saliva and the secretion of the gastric juice. Increased appetite follows its use. Most authors ascribe this favorable influence on the appetite to two factors: The marked bitterness, which increases the desire for food, and the improved digestive power, which, enabling more food to be disposed of, postpones the sense of satiety.

It favors assimilation by stimulating also the intestinal mucous membrane. This ceases after long use, and the effects of overstimulation are observed.

THERAPEUTICS.—Gentian is a valuable bitter tonic. It is indicated in **convalescence** from acute maladies, in **atonic dyspepsia**, in **chronic gastric catarrh**, in **malarial fevers**, and in **chronic malarial poisoning**. The compound tincture of gentian (gentian, orange peel, and cardamom seeds) is a very useful stomachic.

Gentiana quinqueflora is regarded by J. R. Cross as a reliable prophylactic against abortion and all uterine disorders. He

found it especially valuable in **menorrhagia** or **metrorrhagia** depending wholly upon systemic causes, using a tincture prepared as follows: *Gentiana quinqueflora*, bruised fine, 4 ounces (120 Gm.); alcohol, 24 ounces (720 c.c.); pure distilled water, 8 ounces (240 c.c.). The mixture is allowed to stand for fourteen days; it is filtered and is then ready for use. The tincture is given in doses of a tablespoonful every four hours. H.

GENU VALGUM AND VARUM. See ORTHOPEDIC SURGERY.

GERMAN MEASLES. See RUBELLA.

GESTATION, ECTOPIC. See PREGNANCY.

GINGER INEBRIETY. See ZINGIBERIS.

GLANDERS, OR FARCY.—DEFINITION.—This disease develops primarily in the nasal passages and bronchial tubes of horses and cattle, producing a mucous flow. It has been found to be due to the *Bacillus mallei*. Large nodules form in the respiratory passages, and metastatic nodules in the liver, spleen, etc.

SYMPTOMS.—In man the disease does not often present itself. However, veterinary surgeons, butchers, and those surrounded with horses are likely to contract the disease. This was well shown by an unusual accident which occurred recently in the public institute for the examination of food at Czernowitz. Dr. Luksch, the chief bacteriologist, while making some investigations on the *Bacillus mallei* put a large quantity of the bacilli, obtained from an animal from the slaughter house, into a centrifuge. The tube containing the glanders bacilli burst and the contents were scattered over the laboratory. The

fragments of glass were picked up by some of the persons working in the room, and, as it was believed that the bacilli were dead or inert, no great precautions were taken to prevent infection. In the course of a few days all those who were in the room at the time of the accident developed symptoms of glanders, especially of the tracheal and pulmonary type, and two of the victims died within forty-eight hours of the onset of the disease. Dr. Luksch also fell ill.

Glanders occurs in the conjunctiva and on the skin after some insignificant injury. Nodules result and the disease sometimes takes an acute form, beginning generally with malaise, pain in the limbs and back, and terminates in the breaking out of several abscesses over the body.

Two cases of glanders occurring in the human subject. In one case the infection is believed to have occurred through inhalation and in the other case through a scalp wound. Both cases terminated fatally. In one case the incubation period was twenty-five days and the other only five days. In both cases the striking feature was the fact that the degree of prostration was greatly out of proportion to the physical signs. There was early involvement of the larger joints of the body. Pilcher (*Annals of Surg.*, Mar., 1907).

Glanders in the human subject is not the rare disease it is generally supposed to be. Many deaths due to glanders have been indirectly attributed to other causes. In its first stage it greatly resembles typhoid fever; later, lung complications cause it to be mistaken for lobar pneumonia; still later, articular pains resemble rheumatism; suppurative peri-arthritis is a common complication; intramuscular abscesses in glanders, when opened, will be found to have no wall. A pathognomonic lesion of

glanders appears on the face, neck, and shoulders, and sometimes on the body, three or four days before death; it is characterized by pustules with rough, uneven ulceration around the edge. Silkman (*Med. Record*, Oct. 5, 1907).

Glanders can also, as shown below, assume chronicity. As recently (1911) emphasized by Cramp, cases of chronic glanders can easily be overlooked unless one is constantly on the lookout for the disease. Multiple abscess, especially on the extremities, without definite cause, should excite suspicion, as Robin has shown that in 80 per cent. of cases multiple abscesses occur. In his case there was no direct association with horses. The point of entrance of the infection was unknown, no abrasion on the body being present and no history of a wound being obtainable. There was never any nasal discharge. The patient remained apparently cured for six weeks and then showed a return of symptoms. No bacilli were found in the sputum. Extreme exposure to bad weather seems to be a predisposing cause. His case was proved to be one of glanders by laboratory methods and by reaction to the vaccine injections. The patient was apparently cured by vaccine injections.

In the majority of cases the infection occurs through a wound or abrasion of the skin, but in a certain number the infection appears to be through the mucous membrane of the mouth or nose. Whether a previous lesion is necessary or not is uncertain. The incubation period appears to vary from a few hours to a year, the most usual period being four to seven days. Long periods of freedom from any manifestation are a striking feature of chronic glanders. The variety is marked in the initial stages, and continues throughout the

course of the disease. Typhoid fever, septicemia, pneumonia, and rheumatism are only a few of the diagnoses which have been made at the onset; the initial rash when present has most often been mistaken for that of small-pox. The later manifestations simulate nearly all those of syphilis and tubercle, from gummata to osteomyelitis and meningitis. It is difficult to give the average duration, but a considerable proportion of patients die within four months. There are, however, numerous instances where the patient has lived for two or three years, while there are two recorded cases of six and one of fifteen years' duration. It has been estimated that about 60 per cent. of the chronic patients recover. This figure is certainly in excess of the true one, in view of the fact that many patients are considered cured and lost sight of immediately afterward. Seeing, however, the long periods of latency recorded, it is most likely that a certain percentage relapses. Addison and Hett (*Lancet*, Oct. 23, 1909).

DIAGNOSIS.—When the disease occurs in the mouth or nose, bacilli can be found in the mucous flow. When the disease starts internally the bacillus may be found in the sputum, or when the secondary abscesses form. It is of the greatest importance that these should be early recognized.

Another very satisfactory method, especially in cases of nasal and pulmonary glanders, is to inoculate some of the morbid products, or mallein, into animals.

Six cases of human glanders, 3 of which proved fatal. All of the patients gave histories of occupations bringing them into more or less close connection with horses. In 3 cases diagnostic injections of mallein were given, and in all a typical reaction followed. The dose used was 10 to 15 minims. For practical purposes animal inoculation was found to be the most reliable diagnostic pro-

cedure. It was tried in 4 cases with positive results, and in 1 afforded the only means of arriving at a positive diagnosis. An emulsion of the suspected tissue should be inoculated subcutaneously into the abdomen of an adult guinea-pig. If inoculated intraperitoneally the contaminating germs may cause death from peritonitis before the characteristic enlargement of the testes with acute inflammation and engorgement of the tunicae vaginales is produced. The reaction is noticeable in seven to ten days as a rule, but may be delayed for several weeks. Bacterioscopic diagnosis from smears of pus is often most unsatisfactory, the bacilli being generally very scanty. But the cultural characteristics are so definite and so constant as to render the diagnosis simple. Smears of pus on glycerin-agar produce in twenty-four hours a gelatinous, confluent growth, and on potato a brownish growth in forty-eight hours. Histologically there is only one feature characteristic of glandrous lesions—the peculiar nuclear degeneration known as chromatotaxis. The bacilli are rarely to be found in the blood, and leucocytosis is not a marked feature. Bernstein and Carling (*Brit. Med. Jour.*, Feb. 6, 1909).

It is comparatively easy to distinguish the disease from symptomatically similar conditions. The small number of cases reported has given rise to the opinion that the disease is rare in the human subject and that human susceptibility to the infection is slight; but it is probable that fatal cases occur and are reported under other diagnosis, notably small-pox. The case reported was suspected to be small-pox (see the annexed illustrations), but bacteriological examination gave a positive diagnosis of glanders. Hence possible error unless one is careful in the examination of the stained smears or cultures. The deeper staining globules of the glanders bacilli may appear like groups of staphylococci, especially when the bacilli are in dense clumps,

as is often the case in the thick smears from cultures. In gross appearance fresh agar cultures of the pus may also resemble those of *Staphylococcus aureus*, which may explain the frequency of such contamination reported in the literature of bacteriological examinations of glanders. In very thin smears from glanders cultures the apparent cocci are seen to be deeply staining portions of chromatic globules within the faintly staining ground substance of

a microscopic examination as a guide to dosage. A culture from the swab often aids in the early diagnosis. Both guinea-pigs should be kept under observation for a month, and if a lesion of any kind is present autopsy should be performed and cultures made. Arms (Jour. Amer. Med. Assoc., Aug. 13, 1910).

Other methods, especially the complement fixation test and Pirquet's method, are also available.



Fig. 1.—Pustular eruption of acute glanders as exhibited on the day of patient's death, twenty-eight days after initial chill. (Zeit.)
(Journal of the American Medical Association.)

the bacilli. F. R. Zeit (Jour. Amer. Med. Assoc., Jan. 16, 1909).

Strauss discovered in 1886 that material containing virulent *Bacilli mallei*, when inoculated into the peritoneal cavity of male guinea-pigs, developed lesions about the scrotum. This is regarded as the most satisfactory test at present available.

In the diagnosis of glanders the Strauss method is the best; more than one guinea-pig should be used. Before inoculating it is well to make

The Pirquet method for diagnosis of glanders was applied by the writer on himself, infected with glanders in 1894, reaction being obtained from mallein applied to cutaneous ulcers. No reaction was obtained in 10 control persons, however, the skin of whom was scarified and mallein applied. In several other cases seen during the past year mallein obtained a distinct reaction in case of glanders, though not in controls. In 1 case a positive reaction was obtained with mallein through the conjunctiva. Martel (Berl. klin. Woch., March 2, 1908).

Positive agglutination of the glanders bacillus by horse serum in dilution of 1:1000 indicates latent or active infection of the horse furnishing the serum, while in human cases agglutination with dilutions above 1:100 would indicate glanders. Collins (Jour. of Infect. Dis., Oct., 1908).

The complement-fixation test supplemented by the agglutination test on all negative serums is the quickest and most reliable test at the present time.

Glanders antigen, prepared without shaking, but filtered through a Berkefeld candle, gives reliable results and yields a more stable product.

Normal horse serum varies widely in its agglutinating power; therefore a weak positive should be considered in conjunction with the complement-fixation test or with clinical symptoms.

Antigens and agglutination fluid should be prepared from several strains of *B. Mallei*.

While a positive result from guinea-pig inoculation is conclusive evidence of the presence of glanders, failure of the pigs to develop lesions is not proof of its absence. Wade (Jour. of Infect. Dis., Jan., 1913).

TREATMENT.—When the cause is local, energetic measures should be pursued. The erosion or seat of infection should be completely **removed** by means of the **knife**, and cauterizing by means of the **thermocautery**. Constitutionally, the administration of **mercury** has been advocated, but it is doubtful if the case would not prove fatal before the proper constitutional remedies could be had. Gralevsky has however, obtained two recoveries by **incising and disinfecting** the **abscesses** and ordering daily inunctions of 1 dram (4 Gm.) of **gray ointment**.

Owing to the certain amount of analogy between glanders and tuberculosis, Claudius and Michel have

used **creosote** with apparent success. **Vaccine therapy** seems also to give favorable results.

In *chronic* glanders treatment has seemed of little value. Injections of **mallein** have been recommended by Bonomé, while **mercurial inunctions**, according to Gold, have cured some cases.

Case of glanders which for 3 years had been diagnosed in turn as tertiary syphilis, carcinoma, and lupus. When **autogenous vaccine** was used,

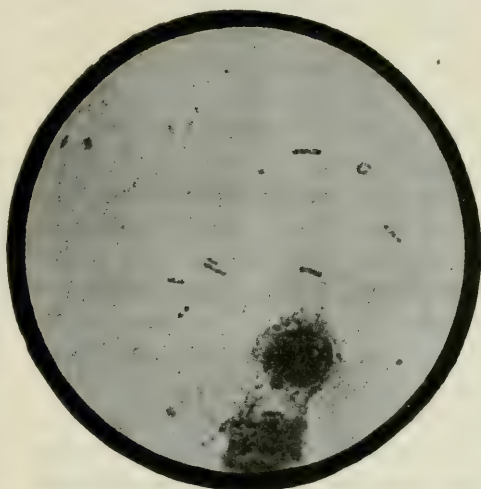


Fig. 2.—Cover-glass smear from opened pustule, showing glanders bacilli. (Zeit.)
(Journal of the American Medical Association.)

it looked at first as if necrosis would destroy the patient's nose, but after 5 injections this organ began to heal and the healing process progressed with the further injections. A spontaneous cure, which occurs in 50 per cent. of all cases, was at least greatly hastened by the vaccine. Fischer (Deut. med. Woch., Jan. 15, 1920).

Chronic glanders of the mucosa in man is usually fatal. A case is cited previously cured by **autogenous vaccine**, no relapse having occurred up to 3 months when the patient was last seen. Zieler (Deut. med. Woch., Feb. 19, 1920).

ERNEST LAPLACE,
Philadelphia.

GLAUCOMA.—To preserve the shape and proper relations of the refracting surfaces of the eyeball, the sclerocorneal coat is kept distended by its contents, which normally press outward with a force equal to the weight of a column of mercury 25 or 30 millimeters in height. To nourish the tissues contained within the outer coat of the eyeball there is a continuous secretion of nutritive fluid; and this fluid, just as constantly, must escape from the eyeball to avoid overdistending it. In pathological conditions the tension of the eyeball may be increased or diminished. Increased tension is indicated by + T 1, + T 2, or + T 3, which indicate different degrees of hardness; and diminished tension is indicated by — T 1, — T 2, or — T 3, the higher number indicating the greater departure from the normal; or it may be indicated by the corresponding number of millimeters of mercury as shown by the tonometer.

Increased tension is generally called *glaucoma*, from the Greek, *γλαυχός*, sea-green. The term was applied on account of the greenish hue of the pupil in elderly people, when dilated, as it commonly is, in glaucoma. But the increased intraocular tension is now recognized as the essential characteristic of the disease.

SYMPTOMS.—The eyeball is found more resistant to pressure than normal. This is tested by pressing on it above or below the cornea through the partly closed lids. The tips of the two forefingers are commonly used. In the early stages the increased resistance may not be noticeable or it may only be present a part of the time. More accurate information is obtained by the use of

the tonometer, which is pressed upon the center of the cornea, while the eye is directed upward. For this test the eye is anesthetized by instilling a 2 per cent. solution of holocaine, as cocaine is liable to alter the intraocular pressure.

A very early symptom is the appearance of colored rings around distant lights at night. The colors are arranged as in the solar spectrum, with the violet toward the light. These halos may be absent in glaucoma, or present when the tension is not increased. Proximity of the iris to the cornea, shallowness of the anterior chamber, frequently precedes any outbreak of other symptoms; and in the later stages the anterior chamber may be obliterated, the iris coming into contact with the cornea. Dilatation of the pupil usually attends glaucoma. In the early stages the pupil still responds to light and convergence, and varies in size from time to time with the variations of tension. Later it becomes widely dilated and fixed. When the tension of the eyeball is much increased, or has increased rapidly, the cornea is found comparatively insensitive to touch.

Pain occurs, and is severe in most cases. It may be limited to paroxysms, or may be constantly present. It is often referred chiefly to the brow or cheek, or the temple or side of the nose. It may be mistaken for neuralgia or the pain of inflammation. In glaucoma that has lasted some time, the large tortuous veins that emerge from the sclera some distance back from the corneal margin are dilated and prominent. During the paroxysms there is generally a marked pericorneal redness. When the tension is very high, or has risen

rapidly, the cornea will be found hazy,—“steamy,”—and may hide the deeper parts of the eye.

When the media are clear the ophthalmoscopic appearances are characteristic. In cases not too recent the optic disc is cupped or excavated deeply, the excavation extending to the extreme margin of the disc, and having abrupt or overhanging sides over which the retinal vessels appear sharply bent. The retinal veins are often dilated and the arteries rather small. The arteries may be seen to pulsate, especially where they pass over the margins of the cup; and the normal pulsation of the veins may be increased. The optic disc is often surrounded by a ring of choroidal atrophy having an edge that shades rather gradually into the normal choroid, called a haloatrophy.

DIAGNOSIS.—Glaucoma may be distinguished from *cataract* by pain, dilatation of the pupil, narrowing of the field of vision, cupping of the optic disc, and absence of opacity of the media except during inflammatory exacerbations. From *neuralgia* it must be distinguished by the fundus changes, and the impairment of visual acuteness or the field of vision, that are present in simple glaucoma, which is most liable to be confounded with that disease. From *iritis* glaucoma is distinguished by the shallow anterior chamber, the dilated pupil, the impairment of the field of vision, the absence of so-called punctate keratitis, and the marked exacerbations and remissions. From *keratitis* glaucoma may be known by the symptoms just enumerated, and the smoothness of the corneal surface. In doubtful cases repeated measurements of the intraocular pressure

with the tonometer must be relied on to determine the presence of glaucoma. The discrimination between different varieties has been indicated in describing them.

ETIOLOGY.—Glaucoma may possibly be caused by excessive secretion of fluid within the eyeball; or by alterations in such fluid which hinder its escape. But the causes that most commonly produce it, and are best understood, act by causing obstruction of the channels of outflow.

The chief channels for the escape of fluid from the eye pass from the periphery or “angle” of the anterior chamber through “Fontana’s space” to a circle of lymphatic and venous channels in the adjoining sclera, called the canal of Schlemm. Adhesion of the periphery of the iris to the cornea or pressure of the iris against the cornea closes these channels.

The liability to glaucoma increases with age; and Priestley Smith has pointed out that the crystalline lens, like other epithelial structures, continues to grow until old age, diminishing the space between it and the ciliary processes, and increasing the liability of these processes to be pressed against the iris and close the outflow channels.

The use of a mydriatic is liable to cause glaucoma through thickening of the iris at its periphery during dilatation of the pupil. Exclusion of the pupil by iritic adhesions is likely to lead to pushing forward of the iris by fluid from the deeper parts of the eye, and blocking of the outflow channels. Dislocation or swelling of the crystalline lens is likely to do the same thing. Causes of swelling of the ciliary processes and iris, as over-

weariness and physical or mental shock, may cause outbreaks of glaucoma; and constitutional conditions, particularly gout, have been accused of causing it. Pain, insensitiveness of the cornea, and cupping of the optic disc are due to the excessive intraocular pressure.

VARIETIES.—Glaucoma in its typical form is marked with exacerbations, during which the tension of the eyeball is increased, with pericorneal redness, increased pain, diminished acuteness of vision, and generally increased severity of all the symptoms. This has been called *inflammatory glaucoma*. It is either *acute* or *chronic*. Sometimes the exacerbation is so severe as to destroy light perception in a few days, or even a few hours—*glaucoma fulminans*. When the increase of tension is preceded or accompanied by retinal hemorrhages it is called *hemorrhagic glaucoma*. Glaucoma quickly returning after iridectomy and compelling the removal of the eye is *malignant*.

When no noticeable exacerbations occur, but the increase of tension and impairment of vision are gradually progressive, the condition is called one of *simple glaucoma*. In simple glaucoma the increase of tension may, for a long time, be scarcely perceptible; or much of the time the tension of the eyeball may be quite within the normal limits. When glaucoma arises in an eye not previously diseased it is called *primary*. When it follows other ocular disease or injury, as wounds causing swelling of the crystalline lens, inflammation of the iris, or intraocular tumor, it is called *secondary glaucoma*.

When the vision has been entirely lost, and the tension is con-

tinuously elevated, the case is said to be one of *absolute glaucoma*.

PROGNOSIS.—Glaucoma not efficiently treated ultimately causes complete and hopeless blindness, usually with a period of great pain. This end may be reached in a few days or only after many years. Treatment may save what sight remains, or some that has been very recently lost may be restored. But vision that has been lost more than a few days or weeks cannot be regained. The prognosis for hemorrhagic glaucoma is extremely bad. Simple glaucoma often pursues its course unchecked by any treatment. Inflammatory glaucoma is quite amenable to the usual remedial measures if applied early. Secondary glaucoma can be cured by removal of its cause, as by the extraction of a swelled or dislocated crystalline lens. The prognosis must always be guarded, for cases mild in the beginning may become fulminating or malignant.

TREATMENT.—**Iridectomy** is the chief remedy for inflammatory glaucoma. It is best done by making with a narrow knife an incision a little back from the corneal margin close to the periphery of the iris. One-fifth of the iris should be removed, quite up to its ciliary attachment. For chronic inflammatory or simple glaucoma **sclerectomy** may be substituted or combined with iridectomy. The scleral incision is made quite obliquely, so that the anterior lip of the wound forms a long flap. The free end of this flap is then cut off with scissors, leaving a triangular, subconjunctival opening in the sclera. A piece of iris may then be excised, constituting the operation of La-grange. An opening may be made

in the sclera by *trephining*. A conjunctival flap is formed, large enough to cover the whole region of the opening. This is laid back and separated from the deeper tissue well into the margin of the cornea. A trephine 2 mm. or less in diameter is then applied and rotated until it cuts through into the periphery of the anterior chamber. The button thus formed is removed, and if the iris tends to prolapse a small portion is excised. The conjunctiva is then replaced and the scleral opening drains the interior of the eyeball into the subconjunctival space. This operation is chiefly used for simple glaucoma. In **cyclo-dialysis** an incision is made through the sclera run back from the corneal margin, and a spatula thrust between the sclera and ciliary body into the anterior chamber.

Sclerotomy may be anterior or posterior. The former consists in making a scleral incision parallel to the corneal margin much as for iridectomy, but longer and not completed, a bridge of sclera being left standing at the middle of it. Posterior sclerotomy consists in making an incision in the direction of an anteroposterior meridian of the eyeball, usually below the tendon of the external rectus, allowing a little of the vitreous to escape.

The common causes of glaucoma must be avoided, particularly the use of a mydriatic, unless iritic adhesions (posterior synechiæ) are present. If operation is not permitted, myotics—as **physostigmine (eserine)** and **pilocarpine**—may be instilled, combined with **cocaine**. Taking blood from the temple and local application of **hot water** to the eye tend to diminish pain.

Operations to establish a filtering scar by incarceration or prolapse of the iris in scleral wound have been devised by Holth and Borthen, but have not been adopted by other operators to any considerable extent. Resection of the cervical sympathetic, done with success in some cases, has not proved superior to less serious measures and has fallen into disuse for the treatment of glaucoma.

In acute or congestive senile glaucoma, after an attempt for a day or so to relieve by medication, and also in the earliest stage of non-congestive glaucoma, before the iris has become adherent the writer does the classical **iridectomy**. In the presence of these conditions he prefers to establish a filtering cicatrix. Weeks (Arch. Ophth., xlix, 316, 1920).

Increased ocular tension in childhood leads to distention of the eyeball: *Buphthalmos* or *hydrophthalmos*. The eye becomes visibly distended, especially the cornea. The pupil remains small; the eye is commonly myopic; vision deteriorates, and is likely to be entirely lost. In some cases **iridectomy** has seemed to check the course of the disease.

Diminished tension of the eyeball follows all perforating wounds, and continues with corneal fistula or cystoid cicatrix. It may also be caused by injuries that cause no wound of the ocular tunics, apparently by nerve influences. Softening of the eyeball commonly attends chronic cyclitis or iridocyclitis, in which connection it indicates serious intraocular changes.

Temporary softening of the eye attended by pain, photophobia, and deep hyperemia of the eyeball is called *ophthalmomalacia*. The attacks may last hours or days, and are liable

to recur. Rest of the eyes, hot applications, and weak solutions of eserine are indicated.

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GLYCEMIA.—This term should in reality be *glucemia*, for it is intended to mean an excess of glucose in the blood, i.e., over and above from 0.06 to 0.11 per cent., the normal amount. It should be borne in mind, however, that, as long ago pointed out by Lépine, there are two forms of sugar termed "glucose," one being approximately pure carbohydrate, the other a more complex sugar, of which glucose forms part, which is the form utilized by the tissues. Again, the prevailing belief is that sugars and starches alone give rise to glucose, but such is not the case; proteins, on being split up, during digestion, into their amino acids, are divided into two portions, one nitrogenous and the other non-nitrogenous, the latter of which is converted into glycogen, along with other starches ingested. This is an important feature in the dietetic treatment of metabolic diseases, since 58 per cent. of proteins is converted into glucose.

In the body, however, there is, as shown by Lusk and his co-workers, a constant ratio between glucose (or dextrose) and nitrogen in the blood, the D:N ratio, which has been found to be 3.65:1. This has made it possible to estimate the severity of a given case. Thus, while waste nitrogen is excreted in the urine, the unused glucose in a diabetic also becomes a waste and is likewise excreted in the urine. Gradually, therefore, as the sugar excretion comes to approximate the D:N ratio, the more does it become evident that less and less sugar is being utilized, until the 3.65:1 is reached, when none is assimilated. Although this indicates a severe case, it does not mean an absolutely unfavorable prognosis, for many diabetics have lived long after this condition was reached, some even showing no sugar.

Children. The sugar content of the blood in infants was studied by Mertz (Arch. f. Kinderheilk., Oct. 16, 1920), who found that the carbohydrate metabolism of infants and young children obeys the same laws as in adults, and that it pre-

sents no special features. Efforts by Strouse (Arch. Internal Med., Dec. 15, 1920) to change blood sugar percentage of 5 normal persons by increased or reduced water intake and excretion failed. This indicates that for practical clinical purposes the blood sugar percentage method is accurate. Daily variations occurred in 5 normal persons. They seem to be influenced by changes in the weather.

The ingestion of sugar increases the glycemia, however, causing the so-called alimentary glycemia.

Blood-Sugar Tests. In a study of 4 different techniques applied to determine the sugar content of the blood in 35 specimens from 28 patients and healthy controls, with the parallel findings tabulated, Host-Hatlehol (Norsk Mag. f. Laegevidensk., Sept., 1920), found that the normal level seemed to be 0.11 per cent. with the Bang, Hagedorn and Folin tests, but that the Myers and Bailey modifications of the Lewis and Benedict method gave higher figures than this in 3 cases, up to 0.142 in 1 case. Various methods will be found described in the article on Diabetes, Vol. IV, pages 20 and 21, but they are all too complicated and take up too much time for the general practitioner. They are best carried out by clinical chemists.

Clinical Applications. Besides *diabetes*, to which the reader is referred, blood sugar tests have been elucidative in various disorders. Thus, in the course of experiments in animals and clinical observations in man, by the Bang micromethod, Chantraine (Zentralbl. f. innere Med., July 24, 1920) found that in *ether narcosis* there is an increase of blood sugar amounting to from one-third to one-half. In *ethyl chloride anesthesia* there is no *hyperglycemia*. After severe *cerebral shock* no *hyperglycemia* was manifest in animal experimentation. In diseases of the *nervous system* there was usually no evidence of it.

GLYCERIN.—Glycerin (*Glycerinum*, U. S. P.), sometimes called *glycerol*, is a colorless, syrupy liquid, of a sweet, warm taste. It is obtained by the saponification of fats. It is soluble in water and alcohol. Exposed to the air, it does not become rancid or

undergo fermentation, and it increases in weight on account of its great hygroscopic powers. Glycerin has decided antiseptic and solvent powers.

PREPARATIONS AND DOSES.

—*Cataplasm kaolini*, N. F. (cataplasm of kaolin), used locally.

Glycerinum, U. S. P. (glycerin); dose, 10 to 120 minims.

Glyceritum acidi tannici, U. S. P. (glycerite of tannic acid); dose, 30 minims; also used locally.

Glyceritum amyli, U. S. P. (glycerite of starch), used locally.

Glyceritum boroglycerini, U. S. P. (glycerite of boroglycerin); used locally and as vehicle for phenol, chrysarobin, vegetable acids, etc.

Glyceritum ferri, quiniæ, et strychninæ phosphatum, U. S. P. VIII. (glycerite of phosphates of iron, quinine, and strychnine); dose, 15 minims.

Glyceritum hydrastis, U. S. P. (glycerite of hydrastis); dose, 30 minims.

Glyceritum phenolis, U. S. P. (glycerite of phenol); dose, 5 minims.

Glyceritum vitelli (glycerite of egg yolk), used for emulsifying.

Suppositoria glycerini, U. S. P. (glycerin, suppository).

PHYSIOLOGICAL ACTION.—

Glycerin in the pure state is slightly irritating when applied locally to the skin or to the mucous membranes; it excites the secretions and causes an increased flow of blood to the parts; in some subjects it produces pain and decided irritation. The ingestion of glycerin causes no appreciable systemic effects. It sometimes acts as a laxative, but does not seem to affect digestion. Injected into the circulation in large amounts, glycerin causes convulsions, due to its hygroscopic powers. Although Pavy as-

serts that the ingestion of glycerin by diabetic patients increases the polyuria, others believe the contrary to be true, and find advantage in its use. The glycerin in stores other than responsible pharmacies is apt to contain arsenic. Vegetable glycerin should be preferred.

The bactericidal action of glycerin is quite manifest on pathogenic bacteria of various kinds.

THERAPEUTICS.—Good results have been obtained in the use of glycerin as a substitute for sugar in the **sweetening agent diet for diabetes**, but care must be taken that pure glycerin be administered.

Constipation.—In constipation the use of glycerin suppositories is followed by excellent results, but a too long continued use may produce rectal irritation. When suppositories are not available, or for any other reason, glycerin may be given by rectal injection, 1 to 4 drams (4 to 16 c.c.) being used. Seifert observed that 50 minims (3.3 c.c.) sufficient to produce a copious evacuation without leaving any disagreeable sensation. In no case did the drug lose its effect, though sometimes given regularly for many months. While toxemic symptoms or rashes may be produced by the use of ordinary enemata, none such have been observed in glycerin enemata. (Burford.)

Boas found that in patients with **hemorrhoids**, however, the insertion of any syringe may be productive of pain. Hollow suppositories of cacao butter may then be employed, each containing 15 minims (1 c.c.) of pure glycerin. This dose is sufficiently large, and acts in fifteen to twenty minutes. It is never necessary to use more than one suppository, though

there would be no objection to giving two.

J. P. Crozer Griffith also noted that occasionally a stinging sensation in the rectum attending the injection, or a burning sensation, lasting a few minutes after the bowels were opened. He found that this did not occur if the glycerin were mixed with a small quantity of water.

In acute **coryza** glycerin (1 part to 4 or 5 parts of water) may be used in spray or applied to the nares by a camel's-hair pencil. Diluted with equal parts of water, it is useful as a **mouth-wash**; it may be applied on a swab to relieve the dry mouth of **typhoid fever** or to facilitate the removal of **sordes**. If the sweet taste is objectionable Ringer recommends a mixture of equal parts of glycerin and lemon-juice. This is also useful in the last stages of chronic diseases, as **phthisis**, to relieve the dry, shiny condition of the mouth and tongue.

Glycerin is valuable as a lubricant, especially in the case of stomach-tubes, where its pleasant taste recommends its use.

Glycerite of phenol is a useful application to **foul-smelling ulcers** and **open sores**. *Glycerite of tannic acid* (containing 20 per cent. of tannic acid) is a useful application in **follicular tonsillitis** and **pharyngitis**. *Glycerite of starch* is used as a vehicle for cutaneous remedies and as a bland protection to superficial **abrasions** and irritated surfaces. *Glycerite of boro-glyceride*, an excellent dressing for **ulcers**, contused and lacerated **wounds**, etc., also does good service as a depletant to the cervix uteri, a tampon, being soaked in it, applied locally to the cervix and renewed daily. In **pelvic congestion** the application of

the tampons should be made two or three times daily, each application being preceded by a copious hot douching.

Glycerite of egg-yolk, or glycerin, besides being useful in preparing emulsions, is an excellent application for chapped hands or face. For this latter purpose glycerin, diluted with 1 to 3 parts of rose water or orange-flower water, is an elegant preparation. *Glycerite of hydrastis* is a soothing and alterative application to **unhealthy** and **sloughing sores**, old **leg-ulcers**, and **sloughing cancerous growths**.

Genitourinary Disorders.—**Renal calculus** has been treated with success by the ingestion of glycerin. The passage of the stones occurred in from six to thirty-six hours in 31 cases reported by Herrmann; in 21 cases there was subjective improvement, while in 33 the remedy proved quite inactive. Its action is ascribed to the elimination of the glycerin by the kidneys. The dose varies from 1½ to 4 ounces (45 to 120 c.c.), diluted with equal parts of water.

Inflammatory and Septic Surgical Disorders.—*Antiphlogistine* and its congeners—*cataplasma kaolini*, N. F., etc.,—are rather popular just now, and deservedly so, for they give relief in a large number of very diverse conditions. Probably in all cases the active therapeutic agency, according to L. Burges, is the hygroscopic power of glycerin. It is simply a method of applying to the surface the principle of the glycerin tampon, which has been so long in use for the relief of pelvic congestion or inflammation. They have their drawbacks, however. Serious burns have been produced by them. That, it may be

said, was the fault of the one who applied the dressing; but accidents will happen, and the difficulty lies in getting it off again quickly enough to prevent injury. Another consideration which often weighs against their use is that they are rather expensive.

Similar good results were obtained by Burges from the application of pure glycerin in localized and superficial inflammations of various kinds. In a case of **chronic eczema** of the leg, the application of a piece of lint soaked in glycerin yielded very satisfactory results. Likewise, in a case of deep **inflammation** of the **palm**, the use of a glycerin pad suitably covered with gutta-percha tissue and cotton-wool brought about prompt relief of pain and probably prevented abscess formation. In another patient with a similar condition of the flexor tendon sheath in one of the fingers, a glycerin dressing caused rapid improvement, avoiding the necessity for operation. In a patient suffering from a large **carbuncle** on the left temple the free application of glycerin on a piece of gamgee covered with gutta-percha subdued the inflammation, relieved the pain, previously severe, and led practically to recovery in a week. The author ascribes the beneficial effect of glycerin in this and other cases to its hygroscopic property. In the carbuncle case it led to a free discharge of serum from the inflamed area; a starch poultice was occasionally applied in order to remove the scaly film of dried serum which formed on the surface. Glycerin was also used successfully in a case of **mastitis**, one of **pleurisy**, and in minor inflammatory conditions, including a case of threatened **superficial gangrene** (diabetic) of the toes.

Rusca and Arndt have recently made systematic use of glycerin dressings in treating **infected wounds**, **phlegmonous inflammations**, **paronychia**, **adenitis**, and **furunculosis**, with excellent results. Glycerin, by absorbing water, decongests inflamed tissues, and tends to prevent suppuration and promote repair. Lucas-Championnière has recommended the following phenol-glycerin combination:—

R Phenol,

Glycerin,

of each 50 Gm. (1½ ounces).

Sterile water . 1000 c.c. (1 quart).

This fluid should be used hot, and applied to the involved surfaces without preliminary cleansing irrigation of the latter.

Besnier advocates the use of the following mixture:—

R Tannic acid .. 0.1 Gm. (1½ grains).

Glycerin,

Rose water,

of each 50 Gm. (1½ ounces).

In localized **hyperidrosis**, glycerin should always be included in the preparation prescribed, if the latter contains formaldehyde in high percentage.

In **nasopharyngeal affections** the application of glycerin is a well-known and effective measure. To it may be added tannic acid, sodium bichlorate, alum, a salicylate, or formaldehyde.

On many occasions, the glycerite of starch may be substituted for pure glycerin with advantage. Editorial (*Tribune médicale*, Feb., 1912; *N. Y. Med. Jour.*, June 1, 1912).

The writer obtained good results with the use of a mixture in equal parts of alcohol and glycerin as a moist dressing in cases where the ordinary dressings induce skin irritation, especially in children of the "exudative diathesis." The irritant properties of the alcohol are practically annulled by the glycerin, its local curative effects, however, remaining unimpaired. The dressing is applied in the usual manner, viz.,

gauze is saturated with the mixture, folded several times, carefully expressed, placed over the skin surface, and covered with some impermeable material and a layer of cotton-wool.

This measure was employed with marked success in cases of **lymphadenitis, mastitis, suppurative processes** in general, **inflammation in the umbilical region in the newborn**, etc. In **bronchopneumonia** the mixture was rubbed on the skin for purposes of counterirritation. In children with sensitive skins it may also with advantage be employed for dressings around the neck in the presence of sore throat. F. Dörken (*Semaine méd.*, Oct. 23, 1912).

In **postoperative bladder paresis** Baisch and Doderlein found that 20 c.c. ($2\frac{1}{2}$ drams) of a 2 per cent. boro-glyceride solution injected into the bladder brought on spontaneous urination in cases where catheterization would otherwise be necessary. The method, according to O. Franck (*Zentralbl. f. Chir.*, Jan. 14, 1911), is almost infallible in both men and women, and avoids the use of the catheter. The solution, to the amount of 15 or 20 c.c. ($\frac{1}{2}$ to $\frac{3}{8}$ ounce), is simply injected with enough force to overcome the resistance of the sphincter and penetrate into the bladder. About 10 c.c. ($\frac{1}{3}$ ounce) returns through the urethra, but the remainder is sufficient to induce evacuation of the bladder within twenty minutes at the most. The ability to void urine spontaneously continues in these cases without the necessity of a second injection. The method was also found, at least temporarily, useful in **bladder paralysis** of mechanical or nervous origin, including **stricture and prostatic enlargement**.

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GLYCOSURIA. — DEFINITION.

—The evacuation of urine containing sugar in sufficient quantity to be revealed by the ordinary tests.

SYMPTOMS.—Glycosuria is a symptom occurring under various conditions and compatible with perfect health. Thus, L. C. Wadsworth reported the case of a man aged 25 who accidentally discovered the presence of sugar in his urine, and who had no symptoms whatever of diabetes, although he passed about 10 per cent. of sugar a day. He was the oldest of 11 children, and examination of the specimens from the other 10 showed high specific gravity and the presence of more or less sugar in all. They were all healthy and passed a normal quantity of urine. Transitory glycosuria does not give any morbid symptoms and is only revealed by examination of the urine.

According to Garrod (1913), no sharp line can be drawn, therefore, between diabetic and non-diabetic glycosuria. A first type of non-diabetic glycosuria is that prematurely termed renal glycosuria. In this there is an excretion of a small daily amount of glucose in the urine, but there is no hyperglycemia; in fact, there may be a reduction in the sugar in the blood below the normal percentage. The most striking feature of this condition is the fact that the daily amount of sugar excreted in the urine is very constant and is not affected by an increased carbohydrate intake. It suggests the existence of an abnormal renal permeability to sugar, similar to the experimental phloroglucin glycosuria. A second type of non-diabetic glycosuric patients is found among the middle-aged, who occasionally pass sugar in their urine. In such there is probably an actual reduction in the carbohydrate tolerance, but it is so slight as to give rise to glycosuria only at those times when the patient has considerably overeaten of starches. This is known to be compatible with many years of life. There are other cases, ones which are true temporary glycosurias, in which the sugar tolerance becomes normal between glycosuric phases. Those cases of temporary glycosuria which are met with in the course of infections such as pneumonia, scarlatina, and secondary syphilis,

and associated with phlegmonous conditions, seem also to belong clinically to the group of non-diabetic glycosurias, though it may be that in such conditions there is some implication of the pancreas. If so, they are of the essential nature of true diabetes. Such is probably the case in mumps, the only infectious disease which is known to involve the pancreas. There seems to be excellent reason to regard the islands of Langerhans as probably the dominant, if not the only, controllers of carbohydrate metabolism. It can scarcely be doubted that the pancreas is subject to minor ailments, as are the salivary glands. It is therefore not impossible that such minor lesions may often be the causative factors in the production of the temporary glycosurias.

It has been a disputed question as to whether the islands of Langerhans alone or the whole tissue of the pancreas control carbohydrate metabolism. In order to determine this, if possible, the writer carried out the following experiment: A portion of the pancreas of a dog was separated from the rest, and its duct ligated. Under such circumstances, the ligated portion underwent atrophy, presumably only the islands of Langerhans escaping the injurious effects of the ligation. Six months later this part of the pancreas was found to be scarcely visible in the mesentery, and at that operation all of the intact portion was removed. The dog then had no secreting pancreas, and was limited to the small fragment presumably containing only islands of Langerhans, and remote from the intestine. After temporary glycosuria and steatorrhea, the dog became able to assimilate fats and carbohydrates nearly as well as a normal dog. The small remnant was then removed, and there immediately resulted an intense glycosuria. On section, this remnant was found to consist of distorted tissue, apparently identical with the tissue of the islands of Langerhans, although the masses were increased in bulk beyond that seen in the normal pancreas. W. G. MacCallum (*Med. Rec.*, Oct. 9, 1909).

Hyperactivity of both the thyroid and pituitary glands, and possibly of the suprarenals, causes, at times, a non-diabetic glycosuria, due, probably, to a disturbance of the interrelation between these glands and the pancreas. Among other forms of non-diabetic glycosuria may be mentioned those from shock or excitement; disease of the brain; tuberculous meningitis, and many drugs and toxic substances.

When cats are excited for even so short a time as one-half hour by being uncomfortably bound, or by being caged in the presence of a barking dog, they develop glycosuria; whereas pain, cooling, or other supposedly harmful factors fail to produce this result, fright or rage being the essential element. It is also interesting to note that there seems to be a relationship between the functions of the adrenal bodies and the development of the glycosuria under these circumstances, because if the adrenals are carefully removed the glycosuria does not appear even if the source of irritation is maintained three times as long as in other cases, although the manifestations of excitement on the part of the animal may be in each instance identical. Cannon, Shohl, and Wright (*Amer. Jour. of Physiol.*, Dec. 1, 1911).

Glycosuria occurs under a bewildering variety of conditions, and in the present state of knowledge no complete system of classification seems possible. It is met with on recovery from chloroform or ether anesthesia; in poisoning from coal gas; after the administration of thyroid extract and of various drugs; after sudden immersion in cold water; in the later months of pregnancy; as the result of mental shock, etc. It happens as an incident in many diseases of the nervous system; it may be a sequel of the acute infective fevers, and it is met with in organic disturbance of the liver, pancreas, and intestinal tube, and also in disease of the thyroid gland or of the pituitary body. G. Rankin (*Brit. Med. Jour.*, Mar. 22, 1913).

The amount of sugar contained in the urine may be determined by various tests (*vide* DIABETES MELLITUS), of which Trommer's and Fehling's are commonly preferred.

The presence of a slight glycosuria cannot be positively asserted on the strength of one test. The following tests in the following order are the shortest accurate method of ascertaining the presence or absence of glycosuria: (a) Fehling's test; (b) phenylhydrazin test; (c) fermentations followed by Fehling's test. Many attempts to hide a persistent glycosuria by self-restricted diet may be detected by the routine use of tests for the acetone bodies. No true diabetic is a good risk for life insurance. Certain patients with transient glycosuria may be perfectly good risks. In studying such cases the race, family history, occupation, age, and weight all have a bearing and should be considered, together with individual tests for the acetone bodies and the use of a test-meal of 100 Gm. of dextrose. Factors which may influence one's estimate of the probable risk are the following: 1. The Hebrew race seems to be particularly prone to this disease. 2. According to Williamson, 13 per cent. of diabetics show that some other members of the family have suffered from this disease. 3. According to Mackenzie, the insuring classes are affected with diabetes to a much greater extent than the working classes. 4. Other things being equal, a glycosuria after 35 years of age is much less likely to be a serious matter than one occurring under this age. Until extensive statistics bearing on this question are at our disposal, it will be impossible to lay down general laws, but the author is personally firmly convinced that many of those who have once shown a glycosuria, when individually considered, may be selected as perfectly good risks. Hart (*Med. Rec.*, Sept. 28, 1907).

That sugar may at times be excreted in small quantities without

one's being able to demonstrate glycosuria, has led the author to make special urinalyses. These disclosed in the sediment, along with yeast cells, certain materials presenting some debatable characteristics. These suggested diabetes, although all tests tried disclosed no sugar. Yeast cells, frequently present in diabetic urine, find in it many ingredients vital for their existence. L. Boros (*Med. Klinik*, June 1, 1913).

In performing Trommer's test for sugar, the writer filters the urine, to which an excess of copper sulphate has been added. The earthy phosphates and undissolved cupric oxide are thus removed, and a clear blue solution remains, which can now be tested accurately with copper sulphate. By this method, detection of 0.4 to 0.2 per cent. of sugar is possible. Sauer (*Münch. med. Woch.*, Mar. 7, 1916).

ETIOLOGY.—Glucose, or dextrose, is a constituent of normal urine, but it is present in too small a quantity to be discovered by the ordinary tests. By the aid of the phenylhydrazin test, however, the presence of a small amount of glucose may be revealed in every sample of urine. Pavy estimates the quantity of sugar formed in healthy urine to be 0.5 per mille. The quantity of sugar contained in the urine is dependent on the amount of sugar present in the blood. According to experiences of Pavy, normal blood contains 0.6 to 1 per mille of glucose; v. Noorden states that the urine will contain sugar enough to be revealed by the ordinary tests as soon as the amount of sugar in the blood exceeds 0.2 per cent. This may be obtained experimentally by ingestion of large quantities of sugar, and in this form of glycosuria—alimentary glycosuria—the variety of sugar in the urine is always identical with that ingested: By ingestion of dextrose, glycosuria, or dextrosuria, is caused; by the ingestion of lactose, lactosuria; saccharose, saccharosuria, etc.

The amount of sugar necessary to produce glycosuria in a healthy person has been found to be:—

Of dextrose, or glucose, more than 180 to 250 Gm.

Of saccharose, more than 200 Gm.

Of levulose, more than 200 Gm.

Of lactose, more than 120 Gm.

When the stomach is full even larger quantities can be absorbed without causing glycosuria. Alimentary glycosuria cannot be produced in healthy persons by ingestion of starch. Miura (*Zeits. f. Biol.*, B. 32) took one morning 1200 Gm. (40 ounces) of rice cooled in water containing 308 Gm. (10 ounces) of starch; he experienced no consecutive glycosuria.

According to Rosenfeld, physiological glycosuria can be differentiated from the pathological variety by the administration of a starch, such as that contained in white bread. It always causes an increase in the glucose in the urine of diabetics, but does not influence the sugar in normal cases.

In the urine of lying-in women lactose generally appears between the second and fourth days of lactation; it again disappears after a short time. When the secretion of milk is suddenly stopped large quantities of lactose are for some time excreted with the urine. Zuelzer administered sugar of milk to lying-in women and found that this substance is more easily eliminated in the puerperal state than in the normal state. Von Jaksch found that in women during gestation the administration of 100 Gm. (3½ ounces) of grape-sugar was followed by appearance of from 1 to 18 Gm. in the urine.

A positive reaction with Fehling's solution during pregnancy is usually due to lactosuria, or to transient, alimentary, or recurrent glycosuria. In such cases lactosuria is probably associated with premature activity of the breasts. If glycosuria in such cases is alimentary it may be disregarded. Otherwise it may be transient or recurrent, or may indicate true diabetes. Glycosuria, late in pregnancy, not exceeding 2 per cent., unaccompanied by symptoms is usually transient, but may persist to the end of pregnancy. It is usually of slight clinical significance, but the patient should be carefully watched. If much sugar is observed early in

pregnancy, it may be impossible to make a diagnosis until after delivery. The condition will then disappear in glycosuria cases, but persist in true diabetes. Pregnancy may occur in diabetic women, or diabetes may become manifest during pregnancy. Either complication is serious. Williams (*Amer. Jour. Med. Sci.*, Jan., 1909).

Among 2200 consecutive obstetrical cases, 88, or 4 per cent., gave a positive test for some form of sugar during pregnancy, labor, or the puerperium. A positive Fehling's during pregnancy is usually due to a lactosuria or alimentary glycosuria and rarely to renal diabetes. Cron (*Amer. Jour. Obstet. and Gynec.*, Dec., 1920).

In various diseases alimentary glycosuria is more easily produced than in health; this has been tried by giving small quantities of sugar (less than 150 Gm.—5 ounces—of glucose) to patients suffering from various diseases. The result of these experiences has been very unsatisfactory. Diseases of the brain, the spinal cord, the peripheral nerves, the muscles, and functional neuroses do not seem to predispose to alimentary glycosuria. According to Strümpell, glycosuria can be produced in a healthy man by giving a large quantity of glucose early in the morning, the stomach being empty. The quantity of glucose necessary to produce this effect varies from 4½ to 5 ounces (135 to 150 Gm.). It is necessary that this quantity be given all at once. The occurrence of this so-called alimentary glycosuria depends not only on the quantity of glucose taken, but also on the rapidity of absorption.

In cases of marasmus, anemia, cirrhosis of the liver, progressive muscular atrophy, and arteriosclerosis no diminished power of sugar destruction could be detected. But in cases of neurasthenia or traumatic neuroses there was a diminished power of sugar destruction, and glycosuria could be induced more readily than in health. In cases of habitual drinkers of large quantities of beer, glycosuria could be readily induced by 3, 2½, or even 1½ ounces (90, 75, or 45 Gm.) of grape-sugar. The same condition Strümpell discovered in some cases after the drinking of an ex-

cessive quantity of beer (2 quarts) rapidly. Alimentary glycosuria does not occur in all great beer-drinkers.

The glycosuria of elderly life is due, in many instances at least, to excessive carbohydrate feeding; this excess is usually confined to some special carbohydrates, sugar, and wheat starch; the early glycosuric of this class is often easily able to care for other carbohydrate foods; the harmful carbohydrates should be detected and eliminated from the food; those that can be assimilated should be determined and permitted; there is a specificity in the metabolism of carbohydrates, as there is in that of proteins; the presence of a small amount (0.5 to 2 per cent.) of sugar in the urine should not be regarded as a matter of trivial importance.

In many persons the capacity of assimilating carbohydrates is largely determined by the time of day when the food is taken. Glycosurics who cannot metabolize carbohydrates when taken for breakfast may dispose of 100 Gm. (32 ounces) of bread taken at a six o'clock dinner. Why this is true it is hard to say, unless it is due to the more hurried way in which many things, both foods and medicines, pass through the body when taken in the morning. To what extent this holds is not known, but it has been observed in many patients. V. C. Vaughan (N. Y. Med. Jour., Feb. 26, 1910).

Transient glycosuria has been observed after concussion of the brain and apoplexy. Higgins and Ogden carried on a study of 211 cases of head injuries to determine the frequency of traumatic glycosuria and its possible relations to the nature of the lesion. There were in the 211 cases 20 that presented glycosuria. They found that after head injury sugar may appear in the urine as early as six hours and disappear within twenty-four, the average time for its appearance, however, being from eight to twelve hours; for the disappearance of the same, from the fifth to the ninth day, and that a small proportion of the cases may exhibit a permanent

glycosuria from the date of injury to the head.

After reading the work of Redard, Hadke, and Kausch, the writer examined, in this regard, 50 cases of fracture. A large proportion showed glycosuria. The chief significance of these observations is in their pointing to shock or cerebrospinal concussion as the principal cause of the condition. Such ephemeral glycosuria does not seem to have any influence on the healing of the injury. Nevertheless, he would postpone operations that are not imperative until the disappearance of the sugar. The chances of non-union might otherwise be greatly increased. A. E. Halstead (Jour. Amer. Med. Assoc., Sept. 7, 1907).

In about 50 per cent. of fracture cases there is a spontaneous or alimentary glycosuria. It usually appears immediately or within a few days, and begins to decrease after 10 days. True traumatic diabetes does not appear until much later. Konjetzny (Mitt. a. d. Grenzgeb. d. Med. u. Chir., xxviii, 860, 1915).

On the basis of Crile's observation that lessening of glycosuria occurs in exophthalmic goiter after thyroidectomy, the writer performed subtotal thyroidectomy in 2 cases of glycosuria. After brief improvement, both died in coma. O'Day (N. Y. Med. Jour., Feb. 24, 1917).

Trivial conditions may sometimes cause glycosuria. Thus, Bazy reported a case of glycosuria in which death followed speedily after the passage of a sound employed to search for vesical calculus. Parry also reported a case which was due to the presence of numerous thread-worms in a child of 5 years. After expulsion of the worms by santonin the glycosuria disappeared and the child regained its former health.

Non-diabetic glycosuria may usually be connected with some antecedent condition, and disappear when this is removed. The amount of urinary sugar is always small, while the bulk of the urine is not increased. Again, diabetic diet exerts little or no influence. Diabetic glycosuria is

eminently chronic, is usually of much higher degree, and is accompanied by polyuria. Stern (Berl. klin. Woch., April 28, 1913).

Study of the literature concerning the question of the relationship of the presence of sugar in the urine for short periods, during the progress of a suppurative process in the middle ear. Beginning with the investigations of Claude Bernard upon the effect of injury in the region of the floor of the fourth ventricle upon sugar elimination, and following through the clinical literature of the subject, the writer concludes that suppurative inflammation of the middle ear, even when it does not extend beyond the boundary of the temporal bone, especially at the acme of its clinical evidence of activity, may be the cause of a transitory glycosuria which should in no way be confounded with, or lead to an oversight of, other pathological conditions which this symptom might indicate. Alfred Zimmermann (Zeit. f. Ohrenheilkunde, Bd. lxxvii, Nu. 3 u. 4, S. 217, 1913).

Physical exercise under defective nutritional conditions may cause glycosuria.

Five cases of men who, after tramping the country for longer or shorter periods, showed temporary glycosuria. On a mixed diet, rich in carbohydrates, the sugar rapidly disappeared. Hoppe-Seyler (Münc. med. Woch., April 17, 1900).

The writer found that participation in a decisive football game caused it in 9 out of the 17 subjects; also in 6 of the 7 substitutes, and in 6 of the 13 spectators examined. It also occurred in 11 out of 27 first-year medical students given a short but difficult written examination. Hammett (Jour. Amer. Med. Assoc., May 6, 1916).

The modern conception of glycosuria takes into account the functions of the ductless glands (Blum, Sajous, Herter and Wakeman, Lorand, and others). As recently stated by Garrod, excess of thyroid secretion tends to induce glyco-

suria, whereas hypothyroidism has the opposite effect. These effects are by no means constant and there may be no lowering of sugar tolerance in a severe case of Graves's disease. What has been said of the part played by the thyroid is equally applicable to that taken by alterations in the pituitary. Hyperglycemia and glycosuria are likely to be present in any disease which causes an excessive supply of epinephrin to the blood, and the evidence at hand suggests that the adrenal secretion may play the chief part in the regulation of the glucose content of the blood. The glycosuria of pregnancy has been ascribed to the well-known influence of this state upon the glands of internal secretion, especially the thyroid and pituitary.

In a paper published a few years ago, Garrod called attention to the very many different morbid conditions which may bring about disturbances of the carbohydrate metabolism, and to the fact that such disturbances may be manifest in several ways, as simple lowering of glucose tolerance, transitory spontaneous glycosuria, and persistent glycosuria with its associated symptoms. The effect of these observations is to obliterate the conception of diabetes as a well-defined disease, and to present the malady as the maximal phase of a series of steps away from the normal of carbohydrate metabolism. Thus, strictly speaking, there is no such thing as non-diabetic glycosuria save possibly the "renal" form.

It is unwise, from past experience, to accept as settled any new theory advanced to explain the cause of diabetes mellitus.

It must now be accepted as positively proved that not only the pancreas, but also the adrenals (chromaffin system), thyroid, parathyroids, and pituitary have a very important influence on carbohydrate metabolism.

Although lesions of the pancreas have been found in a considerable percentage of cases of diabetes, it is now clear that morbid changes in that organ will not explain all cases, even when alterations in the islands of Langerhans are also taken into account. The essential and primary

disturbance may be in one or another of the ductless glands.

There is undoubtedly a marked correlation of the internal secretions of the ductless glands. Thus the internal secretions of the adrenals (chromaffin system) and pancreas mutually retard the action of each other. Fitcher (Jour. Amer. Med. Assoc., Dec. 21, 1912).

About eighteen years ago the writer called attention to the subject of the renal element in glycosuria. He suggests, in regard to phloridzin glycosuria, that the molecules of the phloridzin and its derivatives can pass through the kidney only by breaking their passage through by force. Sugar molecules, following in their steps, can thus slip through the breaches thus produced in the kidney filter. This explains how we get the clinical picture of glycosuria with only the normal proportion of sugar in the blood or even less than this. Lépine (Semaine méd., Sept. 17, 1913).

Although renal diabetes is regarded as a rare condition, the writer believes that it is its recognition that is rare.

He finds less than 25 cases reported in the literature.

To these he adds 2 personal cases. Galambos (Deut. med. Woch., May 27, 1920).

(See also DIABETES MELLITUS.)

Glycosuria may also be due to poisoning by various poisons: morphine, prussic acid, mineral acids, nitrite of amyl, carbonic oxide, chloralamide, nitrobenzol, ergot, etc.

TREATMENT.—The treatment of glycosuria resumes itself into **removal of the cause**—one of the many enumerated. True diabetes is distinguished by its chronicity, the presence of general symptoms, its higher showing in sugar, its polyuria, and its persistence notwithstanding the removal of other than dietetic causes. A very careful study of the patient's habits and general condition is therefore imperative.

It may be found that the patient has the sugar habit, *i.e.*, that he used an inordinate quantity of sugar or sweets. In a woman seen by the writer, the average quantity of candy consumed was 25 pounds a week. As stated by V. C. Vaughan, glycosuria in elderly persons often results from only a certain few carbohydrates used in excess, especially cane-sugar and wheat-starch. The management here consists in ascertaining the harmful ones and removing them from **diet**. All carbohydrates should be abstained from for a week, and if glycosuria disappears oatmeal, at first with water containing saccharin or with butter, later with rich cream, should be used. Then potatoes, peas, beans, etc., one by one, may be given, examining the urine frequently. **Open-air treatment** is of great value.

The writer supports Hest's conclusion as to the value of **uranium nitrate** in glycosuria. He prescribes the drug in doses of 3 grains (0.2 Gm.), gradually increased. The dose is given twice daily after food, and never in less than an ounce of water. C. H. Bond (Hospital, Aug. 31, 1907).

The early recognition and treatment of interstitial pancreatitis, or of pancreatic catarrh, by drainage of the bile-ducts, and thus indirectly of the pancreatic ducts, and the removal of the cause, whether that be gallstones, duodenal ulcer, or other conditions, may be the means of averting diabetes in certain diseases of the pancreas, even after the appearance of glycosuria. **Surgical treatment** is well worth considering, as in a number of cases it has led to a complete disappearance of sugar from the urine, and in others to an arrest of the disease causing glycosuria. A. W. Mayo Robson (Brit. Med. Jour., April 23, 1910).

The **Bacillus bulgaricus** has been recommended by some authors, but found useless by others. **Temporary starvation** has apparently given good results in some cases.

Following the ideas of Guelpa, the writer has resorted to **temporary starvation** in cases of glycosuria, and

the results have justified him in believing that though it may not be a means of cure it has a striking effect in producing amelioration of the symptoms. The explanation is probably to be found in the fact that during the starvation period the various internal secretions are afforded a chance of re-establishing that proper balance among themselves upon which metabolic integrity seems to depend. At any rate it is certain that in cases of glycosuria complete abstention from food over a period of two or three days has a definite influence not only upon the amount of urine excreted, and of the sugar it contains, but also upon the subjective discomforts that sometimes accompany this condition. Rankin (*Brit. Med. Jour.*, March 22, 1913).

When a careful search for a cause, and elimination of all suspicious agencies, has produced no result, the patient should be regarded as a case of true diabetes and the treatment recommended for that disease (see *DIABETES MELLITUS*, Volume IV) instituted.

Glycosuria was found in 4.17 per cent. of 1412 wounded soldiers. The range was from 2 to 20 Gm. with exceptional cases up to 35 Gm. The duration was only for 2 or 3 days, except in 2 cases in which it was respectively 2 weeks and several months. But it finally disappeared in all. No instance of actual diabetes developing after a war wound has been encountered. Rathery (*Bull. de l'Acad. de Méd.*, Oct. 2, 1917). S.

GOITER OR STRUMA; BRONCHOCELE.—The term "goiter" and its synonyms are used to designate an enlargement of the whole or a portion of the thyroid gland of short or prolonged duration.

It has been customary to divide goiters into their histological structure, but it is deemed preferable, in view of the main object of the present work,

to adopt a clinical classification which will aid the-practitioner in identifying those forms or stages of the disease in which medical treatment is of service, from those in which operative measures are necessary. In order to carry out this object satisfactorily it was found necessary to interpret the question first of all from the standpoint of pathogenesis, *i.e.*, the process through which goiters are caused. This will necessitate reviewing briefly the modern conception of the physiological functions of the gland, which, as a rule, is totally disregarded in clinical studies of goiter, and showing how these functions are perverted by the causative agent or agents of this disease.

ETIOLOGY.—Goiter in its various forms may be said to exist in all countries, regardless of race, but particularly in Europe, North and South America, and Asia. In Europe it is most frequently met in Switzerland, France, Austria, Germany, Italy, and certain parts of England.

In some towns of Bavaria 21 to 26 per cent. of the inhabitants have goiter. The endemics correspond always to certain geological formations from which the drinking-water is derived. Water from shell limestone is the main goiter-producer, and to a lesser degree red sandstone, keuper, and zechstone. Lobenhoffer (*Mitteil. a. d. Grenzgeb. d. Med. u. Chir.*, Bd. xxiv, Nu. 3, 1912).

Goiter was present in 11 per cent. of 493 nurses or attendants at the public hospital of Utrecht. Examination of other nurses elsewhere revealed a total of 95 with goiter out of 611, that is, nearly 16 per cent. A tabulation of their home towns shows anew the prevalence of goiter in those from the Utrecht district, with Amsterdam a close second. But in 2 other river districts the proportion

was still higher, namely 6:4% and 9:2% nurses with and without enlarged thyroids. The prevalence of goiter is also marked among recruits from Utrecht. Kappenburg (*Nederl. Tijdsch. v. Geneesk.*, Dec. 9, 1916).

Referring to endemic goiter in the province of Avila, Spain, the writer states that in 1 district with 1780 inhabitants, every one of the young men registered for military service was rejected because of it in 1914. J. Goyanes (*Siglo Medico*, Mar. 9, 1918).

In America it was thought to occur mainly in the northern part of the United States, but the recruiting incident upon the great war showed plainly that it was distributed far and wide throughout the country. At Jefferson Barracks, for instance, Lieut. F. M. Smith in 65,000 men examined found that practically all Middle States were represented, to which all Eastern and Southern states might be added. It is also encountered in South America, Bolivia, various parts of Asia, China and the Philippines. In Canada, in and around the Laurentian Mountains, goiter or "grosse gorge" is usual in all those born and brought up there, even a slight fullness of the gland being observed in a large number of males.

In the North Ogden district, which has a population of 1090, situated at the foot of the mountains north and east of Ogden, out of 280 examined the writer found 70 cases of goiter, which would give us 25 per cent. or practically one-fourth of the entire female population. Nearly all of the cases examined were born in North Ogden and have lived there practically all of their lives. In two instances goiter was developed within three months after moving to North Ogden and drinking spring water. J. W. Pidcock (*N. W. Med.*, Jan., 1913).

In a study of 400 cases of goiter in the Southeast, the writer states that

the colored race exhibits less tendency to thyroid pathology than does the white race; men are less frequently affected than published figures indicate. No particular water supply was under suspicion. E. G. Jones (*Trans. Amer. Med. Assoc.*; *Med. Rec.*, June 29, 1918).

During 2 months' examinations of western drafted men by the writers they were led to conclude that goiter was more common in young men than the experience of the general practitioner would suggest. Definite goiter districts in Oregon and Montana and probably in Nevada were noted, locality appearing of much greater importance than family tendency. Most of the goiters in drafted men were unmistakably toxic, the more toxic cases showing a tendency to nephritis, in addition to the classical cardiac symptoms. Brendel and Helm (*Arch. of Internal Med.*, Jan., 1919).

An examination of 65,507 men at Jefferson Barracks revealed enlargement of the thyroid gland in 1074 instances (1.63 per cent.). In 116 cases (10.7 per cent.) there were toxic symptoms. These men were rejected with a diagnosis of hyperthyroidism or exophthalmic goiter, depending on whether or not exophthalmos was present. Oklahoma had the highest percentage (38 per cent) of goiters, followed in order by Texas, 20 per cent.; Tennessee, 11; North Dakota, 8.7; Nebraska, 8; Indiana, 6.6; Iowa, 6.2; South Dakota, 6.2; Michigan, 3.3; Wisconsin, 2.7; Arkansas, 2.3; Minnesota, 1.3; Missouri, 1.1; Kansas, 1.1; and Illinois, 0.6 per cent. Texas ranks highest in percentage (20 per cent.) of goiters in which there were toxic symptoms, followed in order by North Dakota, 19 per cent.; Kansas, 14.2; Wisconsin, 13; Missouri, 12.6; Tennessee, 12.5; Iowa, 11.2; Arkansas, 10.5; Illinois, 10.1; Nebraska, 10; Oklahoma, 8.3; Indiana, 7.2; South Dakota, 4.1; Minnesota, 3.8, and Michigan, 0 per cent.

The men from whom these figures were compiled were between the ages of 18 and 31 years.

Contrary to the prevailing conception, the states in the Great Lakes region stand rather low in the list with regard to the percentage both of simple and of toxic goiter. F. M. Smith (Jour. Amer. Med. Assoc., Feb. 15, 1919).

Much etiological prominence has been attached to the influence of altitude, owing to the fact that Bircher's map of the distribution of goiter in Middle Europe indicates a predilection of the disease for mountainous districts. Its presence in flat countries, however, such as those stretching from the north of Paris toward Belgium, along the valley of the Thames, the low-lying districts of Ontario and Michigan, where cases are very frequent, and in the Chitral and Gilgit Valleys of India, where, according to McCarrison, goiter is endemic, tends greatly to diminish the importance of this cause.

The water supply has held a prominent place among the many causes of goiter vouchsafed. Kocher found that in the canton of Berne, Switzerland, there were actual goiter fountains which almost invariably produced goiter in the children who drank it. On the other hand, in locations where goiter prevailed, families which received water from elsewhere avoided the disease.

Extensive experiments in dogs, rats, guinea-pigs, and monkeys in which enlargement of the thyroid followed ingestion of water from certain springs in regions where goiter is endemic. Goiter also developed in the animals when the residuum after filtration of such water was added to water from springs in other regions free from goiter. Wilms (Deut. Zeit. f. Chir., Jan., 1910).

The writer caused struma in rats by causing them to drink water of

the particular geological sources that are known to cause it in human beings. His series embraced 120 animals, was carefully controlled, and consisted of animals from various districts. Bircher (Deut. Zeit. f. Chir., Bd. cxii, Nu. 4-6, 1911).

Goiter developed in 2 rats at Buenos Aires that were given exclusively water from a remote focus of endemic goiter. The water had been 5 days on the way. Houssay (Revista del Inst. Bact. de B. A., May, 1920).

Modern evidence seems clearly to show that certain agents ingested through the intermediary of water may cause the disease. Calcium has been incriminated by numerous writers, owing to the fact that in their experience goiter always coincided with the presence of an excess of this metal in the water consumed. Morris refers to a district in England in which the water is excessively rich in calcium, and in which goiter cases are correspondingly numerous, while the inhabitants who, in the same district, use rain water as sole beverage are free from the disease. The silicates, magnesia, alumina, iron, manganese, copper, lead, and other mineral constituents, have been regarded as possible causes. The more recent researches have tended to show, however, that these were but subsidiary factors.

To ascertain positively whether the richness of the water in lime salts, magnesium, and iodine contents caused the disease, the writer left ineffective water in contact with rocks from the streams of the goitrous areas. None of the animals using this water developed goiter except after long periods. He then put the struma-producing water in contact with Jurassic rocks, and no goiter was produced in the animals taking it. It thus appeared that the goitrous toxin was fixed by some

rocks, *i.e.*, the rocks lose their efficacy just like the filter. The presence of colloid in goiter led him to try dialysis. The dialyzed portion gave no goiter to animals. The water remaining in the dialyzer produced it readily. Gouget (*Presse méd.*, p. 709, 1911).

All modern data speak against any special geologic formation as responsible for the development of goiter. The experiences of Chagas of Brazil in the study of the parasitic thyroiditides of that country, together with those of Gaylord in the United States in connection with endemic goiter in fishes, lead to the same inference as the findings of the authors, *i.e.*, that the exciting cause of goiter may be a micro-organism. Animals treated with goiter water develop an antiserum which yields reactions to the said water. This could be interpreted of course as due to fouling of the water in transport. Weichardt and Wolff (*Münc. med. Woch.*, Feb. 29, 1916).

Theodor Kocher long held that the prevalence of goiter depended upon the abundance of organic matter in pathogenic waters rather than upon the water itself, as obtained from its source. Waters has also emphasized the importance of organic rather than mineral agents as cause, at least as shown by his studies of goiter in India, where the rainy season (a time when organic matter is rapidly disseminated) is known greatly to increase the number of cases, even among white residents.

Some investigators have attempted to show, however, that water-borne agencies do not play a preponderating rôle in the genesis of the disease, as has been believed. The evidence is, however, not convincing because the toxic agent or agents may have been introduced through the intermediary of contaminated foods.

Animal experimentation shows that goiter and cretinism may arise without the presence of water. Epidemiological studies prove that their appearance and disappearance in families and houses show that the cause of the disturbances must be sought in the house itself and in the apartments in the immediate neighborhood of the stricken persons. The transference of the disease by an intermediate host is probable. A. Kutschera (*Münc. med. Woch.*, Feb. 25, 1903).

Goiter is not known to occur spontaneously in rats at Zurich, but the investigators were able to induce it at will by taking the rats to the endemic foci, whether the animals were given the natural water to drink or the water was boiled for them, or they were not given any water or only water brought for them from Zurich. The research carried on with rats at 8 different endemic foci gave positive results in from 40 to 70 per cent. of all the experiments. The nature and origin of the water given the rats to drink had no influence on the outcome. Rats kept at Zurich and given water brought from endemic foci at first did not develop goiter, but later there were a few instances of its occurrence; contact infection could not be excluded in these cases. In the endemic foci the animals developed the goiter even when they were given only water from non-goitrous regions. Hygiene Institute at Zurich (*Jour. Amer. Med. Assoc.*, from *Münc. med. Woch.*, Aug. 19, 1913).

Deficiency of the iodine content of foods has been suggested as a possible cause of goiter. A comprehensive research by Forbes, Beegle, Fritz Morgan and Rhue (1916) however has tended to suggest that factors other than diet promised results of greater significance.

The writer concludes a comprehensive study of the prevalence of goiter in different regions and alti-

tudes of Switzerland, by the statement that goiter is a functional hypertrophy of the thyroid caused by the effort of the organism to make up a deficit in the iodine supply. As the iodine naturally is supplied in the food, goiter is prevalent in regions where the vegetation lacks the standard proportion of iodine. The main goiter regions were found by the writer at a moderate altitude, from 600 to 1000 meters. Above and below this, goiter is less prevalent. In 1 comparatively exempt canton he ascertained that the cooking salt used had an unusually high iodine content. In certain years goiters develop more numerous than in others. This may be due to rains which wash the salts out of the soil. A sandy soil yields them up more readily to the rains. In a rainy season, also, the vegetation grows less luxuriantly and takes up less of the salts in the soil. At altitudes above 1000 meters, the vegetation grows so luxuriantly when it gets a chance to grow that it works deep into the soil and takes up the salts. Iodine-containing manure in the regions where goiter is endemic might supply the vegetables with the needed iodine, and thus exterminate goiter. Hunziker (Corresp. bl. f. schweizer Aerzte, Feb. 23, 1918).

That the exciting cause is a pathogenic organism or the toxin of such has been urged by Poncet, Jaboulay and Riviere, Klebs, Kocher, Lustig and Carle, Waters, and others. Kocher found that "goiter-water differs from goiter-free water in containing many more micro-organisms."

The disease is regarded by McCarrison as one in which the seat of infection is most probably the intestinal tract and of which the enlargement of the thyroid is the dominant symptom. These conclusions are based on the following facts: Goiter is caused by an organism invading the body of man. All the evidence

so far accumulated points to the intestine as the seat of infection. In nature it lives in the soil of infected localities, and is very limited in its distribution. It is conveyed to man in the drinking-water, by contact with soil, or by other means yet undetermined. It requires a calcareous soil to enable it to flourish and produce goiter. It can be conveyed by man to places where the disease has not hitherto prevailed and, if the conditions are favorable there, it can produce the disease. The virus is, therefore, given off by persons suffering from the disease, in some way as yet undetermined, but not unlikely by means of the feces. The most susceptible individuals suffer most and first, namely, the children.

Goiter in Sanawar, India, was found by the author to be due to the presence of living micro-organisms in the water supplied to the children for drinking purposes. The disease can be eradicated, he holds, by the provision of a chemically and bacteriologically pure water. Most of the contamination in the water was derived from human fecal matter, *i.e.*, to a variety of colon bacillus. McCarrison (Indian Jour. of Med. Research, Jan., 1914).

It is my belief that in Switzerland where fresh feces are used as fertilizing material, this habit is the main underlying cause of the great prevalence of goiter and cretinism in that country. In Bosnia where goiter also prevails extensively the filthy habits of the peasants who use their fingers to fish their food out of a common bowl is also traceable to fecal contamination and not contact as Kutschera believes.

Organisms of the ameba type, and resembling the hematozoön of ma-

laria, were thought by Waters (1897) to cause goiter. Grasset the following year found such a parasite in the blood of very recent cases. Chagas attributed a form of goiter met with in Brazil to *Conorhynchus megistus*, a biting insect, while Brumpt states that various insects, especially the bedbug, can act as hosts. Evidently, the causes of endemic goiter vary.

That toxic products of metabolism, an excess of nucleins, etc., can also produce goiter is suggested by many facts. Excessively nitrogenous foods were included by Munson (1895) among the causes of goiter, which he found to prevail to the extent of 2.36 per cent. among American Indians. Baumann noticed that flesh diet stimulated the thyroid in dogs to active hyperplasia. Suzuki produced enlargement of the thyroid in rats by feeding them with cooked rice mixed with rat feces, and also by injecting the latter subcutaneously. McCarrison observed the same result in animals which drank only water polluted with feces. Marine found recently that in the trout the feeding of liver and heart produced goiter. Reid Hunt has noticed the same result in white mice fed on liver.

The feeding of the highly artificial and incomplete diet of liver and heart muscle is the major factor in the causation of fish goiter, and the first essential in treatment is to provide some other food that meets the animal's requirements. A natural food of trout is fish and the experiments of the past two years show that when sea fish is fed to these trout existing goiter is cured and the development of goiter is wholly prevented. David Marine (Jour. of Exper. Med., Jan. 1, 1914).

Children are known to be more sensitive to the disease than adults,

while, as stated by Kocher, "the female is more frequently the victim of goiter than the male."

The influence of heredity has been doubted, but this is unwarranted. Many instances have been recorded. In a case reported by Schäffle, for example, the patient's brother and sister, mother, grandmother, great-grandmother, two aunts, and two grandaunts had goiter. E. E. Holland also described a family in which goiter occurred in five successive generations. In several families of this kind the various generations had not lived in the same district.

A series of comprehensive experiments in goats led the writer to conclude that congenital goiter is due to the action on the fetal thyroid of toxic substances derived from the maternal intestine. These substances are the products of micro-organisms originating in fecally contaminated soil which are conveyed to man and animals by infected food and water. McCarrison (Indian Jour. of Med. Research, July, 1916).

As to the process engendered by these many causative agents, certain bacteria and their toxins, especially in the course of infectious diseases, may cause an inflammatory reaction, focal hemorrhages etc., but in chronic goiters the pathogenic toxics, *all probably of bacterial origin*, first stimulate the organ to increased activity—a process that may be followed by degenerative changes which impair thyroid functional activity.

Chronic tonsillitis, catarrhal disorders of the nasal cavities and sinuses, gastroptosis and enteroptosis, by causing the retention of fecal masses, chronic constipation in susceptible cases, pregnancy owing to the excess of wastes added to those of the mother by the fetus, are all

sources of toxins or poisons capable of provoked defensive reaction of the thyroid. When the organ is unable to carry on this excess of functional activity it enlarges, constituting goiter. If long persisted in it becomes the seat of pathological changes which constitute the various forms of goiter.

To understand the process of goiter formation thoroughly it is necessary to review the modern conception of the physiology of the organ.

Functions of the Thyroid and Parathyroids.—Swale Vincent, in a review of these functions states that the purpose of the internal secretion of the thyroid (including the parathyroids, I would add) is "to prevent poisoning by products of metabolism," and also "by infection from without."

[As far back as 1903, in the first edition of "Internal Secretions," I urged that this function of the thyroid formed part of the general defensive process we term "immunity," and in 1907 in the second volume of the same work identified the thyroparathyroid secretion as the Wright opsonin. Lévi and de Rothschild, of Paris, in the second volume of their "Physiopathology of the Thyroid Gland," write: Sajous has attributed, among the functions of the thyroid gland, a rôle to the latter which he assimilates to that of the opsonins, and to autoantitoxins. More recently, Miss Fassin, M. Stepanoff, and M. Marbé (Pasteur Institute) have confirmed on their side the influence of the thyroid on the blood's asset in alexins and opsonins. Lorand, referring also to the confirmation of my views by European investigators, states that they prove "the intimate relationship between the thyroid and our immunizing functions." C. E. DE M. S.]

The fact that the antitoxic and bactericidal resources of the body are largely dependent on the functional perfection of the thyroparathyroid mechanism is, the writer believes, as clearly established as is the

influence of this mechanism on metabolism.

Sajous showed in 1902 that the injection of various bacterial toxins into man and the lower animals excited, more or less actively, according to their virulence, the thyroid gland's functional activity, while Bayon's researches show that the injection of bacterial toxins into the gland may lead to the actual formation of goiter. Farrant also has lately induced marked thyroid hyperplasia by the injection of diphtheria toxin into guinea-pigs; he demonstrated that the hyperplasia so induced could be controlled and greatly mitigated by the administration of thyroid extract at the same time as the toxin. Fassin found that the germicidal power of the blood was diminished by thyroidectomy. Charrin, Vincent, and Jolly drew attention to the fact that animals deprived of their thyroid glands are rendered very susceptible to infectious diseases, to which they readily succumb. Hürthle observed that by ligaturing the bile-ducts in dogs the thyroid secretion was increased; he attributed this change to the passage of certain constituents of the bile into the blood. Turro has found that the juice of swine and sheep thyroids dissolved almost entirely the comma thyroid and anthrax bacilli, as well as the *Bacillus coli communis* and streptococcus. Gley showed that the blood-serum of thyroidectomized dogs is more toxic than normal serum and gives rise to convulsions when injected into animals, while de Luca and d'Angerio have found that the urine of these animals contains a higher percentage of toxic substances than is normal, and that thyroid extract administered to them counteracted this toxicity.

While making every allowance for errors of observation, these and other findings of a like nature justify the belief that the thyroid gland contributes largely to the body's antitoxic and bactericidal resources. R. McCarrison (*Lancet*, Feb. 8, 1913).

The manner in which the various forms of goiter, to be described, arise is readily understood when this antitoxic function of the thyroparathyroid apparatus is taken into account. Briefly, we are dealing with excessive functional activity or abnormal effort on the part of the gland and its glandules to supply the excess of secretion *necessary to aid in destroying the toxic or toxins which have accumulated in the blood*. This abnormal functional activity is accompanied by more or less marked hyperemia of the organ, whose vascular channels are relatively enormous, and it enlarges—sufficiently at times to constitute a tumor, *i.e.*, a goiter.

The influence of a toxemia is well exemplified by three familiar forms of thyroid swellings, *acute thyroiditis*, *strumitis*, and *congenital goiter*, which are known to be caused in most instances by a toxin, toxic waste, etc.

For *treatment* see page 68.

THYROIDITIS.

Inflammation of the thyroid gland, attended by swelling, thus forming temporarily a goiter, may appear in the course of certain infectious diseases, especially typhoid fever, diphtheria, scarlatina, measles, parotitis, tonsillitis, erysipelas, pneumonia, pertussis, dysentery, rheumatic fever, puerperal fever, orchitis, syphilis, and influenza.

Case of a woman who developed on the second day after parturition a mild infection, from which arose an abscess of the thyroid gland. Suppuration occurred, the abscess was opened, and recovery ensued. This complication is regarded as a very serious one. Suppuration may occur in a previously existing goiter, which is not a true infection, or in a previously healthy organ, a true acute thyroiditis. It begins abruptly with

a chill and swelling in the thyroid region, diagnosis being easy on account of the superficial location of the gland. It may involve the whole or only a part of the gland. The swelling moves up and down with the ascent of the trachea and in deglutition. The frequency of thyroiditis in women shows that they have a predisposition to it. The thyroid participates in congestion of the genital organs during menstruation and in pregnancy. In many pregnancies the thyroid has become enlarged, and is particularly susceptible to infection; still suppurations in the puerperal state are rare. P. Lecine and Metzger (*Ann. de gyn. et d'obstét.*, Feb., 1910).

During the past ten years a number of cases of acute thyroiditis, 7 in all, have come under the writer's observation. These cases are of particular interest from an etiological standpoint, as in all except one case the inflammation of the thyroid gland occurred with or directly after attacks of tonsillitis. C. F. Theisen (*Albany Med. Annals*, Aug., 1913).

Various poisons have also been known to cause acute thyroiditis, thus constituting a form which has been termed "toxic thyroiditis." Iodine and the iodides are especially active in this connection. It is more apt to occur when the iodides are administered after mercury has been used.

Acute thyroiditis in a robust woman of 28, free from goiter, who was treated with mercurial inunctions and potassium iodide for chronic eczema of the leg on the presumptive diagnosis of a syphilitic etiology. Under this treatment the thyroid gland became enlarged. There were dryness of the skin and falling out of the hair, accompanied by rapid emaciation, palpitations, insomnia, tremor, pigmentation, enlargement of the glands, diarrhea, and occasional delirium, the syndrome suggesting also exophthalmic goiter. No improvement was

apparent after suspension of the iodide until **thyroid** treatment was instituted, supplemented by **sodium phosphate**, when the symptoms rapidly subsided to complete recovery by the end of the fourth month. Warschauer (Berl. klin. Woch., Dec. 9, 1907).

Case in which inflammation and swelling with high fever developed in a previously sound thyroid after the patients had taken 2 spoonfuls of a 5 per cent. solution of potassium iodide. In a second case the acute thyroiditis developed after the first spoonful and became more intense after 2 more spoonfuls. The salt had been given in this case after a course of mercury. The thyroiditis subsided completely in a week. It was evidently a manifestation of iodism, the picture including palpitations and a pulse running up to 120. Sellei (Deut. med. Woch., March 23, 1911).

The pathological process awakened may be of two kinds: (1) Excessive functional reaction of the gland to antagonize the accumulation of toxins due to the infection or other poisons that have accumulated in the general circulation; (2) invasion of the gland by pathogenic bacteria of the general infection present, which occurs as a complication of the defensive hyperemia. It is probable, however, that acute thyroiditis may be due to bacterial invasion alone, since some cases may either develop early in the course of, or at the end of, the general disorder.

Out of 96 cases of acute thyroiditis collected from literature, 7 occurred as a complication in the course of acute rheumatism, 6 in acute pneumonia, 6 in enteric fever, 4 in erysipelas, 4 in influenza, 4 in malaria, 4 in diphtheria, 3 in tonsillitis, and 3 during the puerperium. W. Sibbald Robertson (Lancet, April 8, 1911).

Three cases of scarlatina in which the thyroid increased in size during

the course of scarlet fever. It returned completely to normal size in one boy of 13 by the thirtieth day, but in another boy traces of the swelling were still perceptible on the sixty-sixth day, as also in the third patient, a young woman, on the forty-third day. The thyroiditis in her case was evidently one of the primary manifestations even though the scarlet fever had been of a mild type. Bauer (Monats. f. Kinderheilkunde, Bd. ix, Nu. 10, 1911).

Case of a man with a large unilateral goiter of long standing in whom, about a week after the temperature had reached normal in recovery from pneumonia, slight fever reappeared and pallor and cachexia began to be manifest. By exclusion the disturbance was finally ascribed to the thyroid gland, and although there was no local edema, redness, or abnormal heat, but merely a sensation of deep fluctuation and slight tenderness, it was decided to operate. Upon introduction of a trocar there was evacuated about 2 tablespoonfuls of pus, which yielded a pure culture of pneumococcus. After this the patient's condition improved, and complete recovery followed. C. Roubier and A. Goyet (Lyon méd., May 4, 1913).

Suppuration occurs occasionally, particularly in acute thyroiditis due to typhoid fever, where it appears in about 60 per cent. of the cases of thyroiditis from this cause. In some instances, the abscess may be sufficiently large to provoke pressure upon the trachea and suffocative symptoms. The cases may terminate by resolution or, very rarely, by gangrene.

The thyroiditis associated with mumps and influenza has never been observed by the writer to suppurate; all the malarial cases of which he has records, and those connected with acute rheumatism, tonsillitis, erythema nodosum, and other rheu-

matic affections, ended in the same way. On the other hand, in all the pneumonic and puerperal cases and in a very large majority of the typhoid, diphtheria, and erysipelas cases, the inflammation went on to suppuration. W. S. Robertson (*Lancet*, April 8, 1911).

SYMPTOMS.—These vary with the cause. When acute thyroiditis is primary, there are usually the chill, general malaise, and headache, which, as a rule, initiate febrile disorders. The region of the gland then becomes painful, first on one side, then on both sides,—in most cases,—while in others the entire gland is involved from the start. The pain, which radiates to one or both ears, the teeth and jaws, and even the chest, shoulders, arms, and occiput, may be very severe and is usually lancinating. It is aggravated by pressure on the gland or by extension of the neck, a fact which causes the patient to bow his head in order to relax the anterior cervical muscles.

Swelling of the gland sometimes appears on the first day, but usually only on the second. The organ may become very large, attaining, sometimes, the size of a hen egg. Pressure symptoms, dysphagia,—which may occur as the initial symptoms, due to compression of the esophagus,—and dyspnea—sometimes due to pressure on the trachea when the entire gland is involved—are always present. Cough and hoarseness are also produced in some cases.

Case of a man aged 42 years who, during convalescence from an attack of typhoid fever, began to complain of dysphagia. The thyroid gland became enlarged and tender, but remained soft. There was some elevation of temperature, extreme dysphagia, and severe dyspnea. Grad-

ually, however, the case recovered. W. Egbert Robertson (*Amer. Jour. Med. Sci.*, Jan., 1902).

Report of a woman of 28 years with no particular history, who entered the hospital with a round tumor, the size of a mandarin orange, in the neck. Shortly after, typhoid fever developed, from which she recovered. The tumor enlarged and was removed. It contained chocolate-colored pus. Cultures showed colonies identical with Eberth's bacillus. The latter may cause a thyroiditis or a strumitis, according as it locates in a healthy or altered gland. Liebermeister and Hoffmann found 6 such abscesses in 1700 typhoid cases. It usually occurs during convalescence.

Eberthian strumitis may terminate by resolution; suppuration is not infrequent, occurring 6 times in 15 according to Liebermeister; in rare cases death may ensue due to tracheal compression. **Evacuation of pus** and **strumectomy** is the rational treatment. Landivar and Roffo (*Prensa med. Argent.*; iii, 49, 1916).

When acute thyroiditis occurs in the course of an infectious disease, there is, as a rule, a rise of temperature, and all the phenomena above described develop, the swollen gland being sometimes exquisitely sensitive to the touch and markedly congested. The symptoms due to the pressure of the inflamed gland are, as a rule, more severe and may include epistaxis and edema of the larynx.

Seven cases observed at Dresden during two years, all the patients being young women. In all there was some history of recent pleurisy, pneumonia, or apical catarrh. Iodine induces exacerbations and recurrence. Dunger (*Münch. med. Woch.*, Sept. 8, 1908).

Case of acute thyroiditis with edema of the glottis following exposure to epizootic of horses. The patient, a hostler aged 56 years, while engaged in his usual work,

suddenly fell to the ground in a choking fit from edema of the larynx attended with rapid and great enlargement of the thyroid gland. Under **morphine**, **ice-bag** about the neck, and **adrenalin spray** whenever the dyspnea became excessive, dyspnea and hoarseness, the most marked symptoms, disappeared within three days, and on the fourth day the patient was able to leave the hospital. Lewis and O'Neill (*Jour. Amer. Med. Assoc.*, Nov. 12, 1910).

In some instances, the gland is not greatly swollen. To determine that it is the organ actually involved, swallowing will cause the painful area, the gland, to rise, provided, of course, the head is not bent backward, which would immobilize the organ. Cardiovascular disturbances, slight exophthalmos, tremors, emaciation, and other symptoms suggesting Graves's disease (*q.v.* this volume) are sometimes observed.

Uncomplicated acute thyroiditis usually lasts but a few days, the swelling subsiding gradually. Sometimes, however, the disorder may persist several weeks.

Case of simple acute thyroiditis in a woman 67 years old who had been gouty for a great many years. The disease attacked her suddenly after a fit of indigestion. The right lobe of the thyroid gland was augmented in volume and of a hard consistence. At the same time serious general symptoms made their appearance. Sleeplessness and loss of appetite were very pronounced; the patient complained of pains in all her limbs, and already it was noticed that she had decidedly lost flesh. A month later the right lobe was found to have become reduced in size, while the left lobe in turn showed enlargement and the patient had lost more than 11 pounds in weight. At the end of a few weeks more it was observed that the median lobe was participating in the

inflammation. Then there followed a rather rapid and progressive improvement, which ended in recovery, though the two lateral lobes still remained voluminous. E. Weber (*Revue méd. de la Suisse Romande*, March, 1909).

When suppuration develops the case is protracted until the pus is evacuated. The abscess is rarely single, usually consisting of numerous purulent foci, which tend to run together, and to break through the adjacent soft tissues, including the skin. When left to itself the purulent infiltration may cause serious complications, such as perforating the trachea or esophagus, or penetrating by burrowing to the mediastinum, pleura, and lungs, causing septic pneumonia, or along the sheaths of the great vessels of the neck, etc. Fluctuation may be difficult to obtain, owing to the smallness and dispersion of the purulent foci. Even an exploratory puncture may prove misleading in this respect.

Suppuration took place in 40 of 96 published cases. The thyroiditis associated with mumps and influenza had never been observed to suppurate. The malarial cases, and the cases connected with acute rheumatism, tonsillitis, erythema nodosum, and other rheumatic affections, ended in the same way. On the other hand, in the pneumonic and puerperal cases, and in a large majority of the typhoid, diphtheria, and erysipelas cases, suppuration occurred. In 27 of the suppurative cases there was a pre-existing goiter. The suppuration usually takes the form of small miliary abscesses in the bands of connective tissue that traverse the gland. W. Sibbald Robertson (*Lancet*, April 8, 1911).

The sequelæ of these cases are sometimes serious, owing to the destructive lesions produced in the organ

during the active stage of the morbid process. Fibrosis may ensue and cretinism or myxedema may appear. Such a case may even have begun with symptoms of exophthalmic goiter.

Case of a girl that was normally developed until ten months old, when she had an attack of acute thyroiditis that lasted one week, and was accompanied by fever, swelling of the gland, and symptoms of pressure on the trachea. The throat was normal; there was no abscess formation. After recovery there was complete atrophy of the thyroid. The child's growth and development ceased immediately, and she became a typical cretin, 33 inches in height and weighing 33 pounds at the age of 7 years. Shields (*N. Y. Med. Jour.*, Oct. 1, 1898).

Acute non-suppurative thyroiditis is more common than generally believed; it simply escapes recognition in many instances. It may be caused by apparently insignificant factors. Burke described a recurring thyroiditis in a woman doing translating for ten to twelve hours a day, the constant turning of the head to the left to consult the original work and the friction from the collar having caused irritation of the left lobe of the thyroid with recurring inflammation. Apelt also reported a typical case of exophthalmic goiter developing after an acute thyroiditis, which had developed in turn after an abscess in a neighboring tissue. Schwerin (*Münch. med. Woch.*, Oct. 13, 1908).

DIAGNOSIS.—The symptoms just enumerated usually render a diagnosis easy in well-marked cases. The conditions with which it may be confused, particularly at the start, are: when unilateral, with mastoiditis and parotitis; esophageal abscess, from which it may be differentiated by mobility of the gland during deglutition; the acute hyperemia of the

thyroid previously described, sometimes attended with pain and fever; adenitis or cellulitis of parts adjoining the thyroid; hemorrhagic goiter due to rupture of some thyroidal vessel; cancer or tuberculosis of the thyroid, described below. All these disorders have characteristics which careful study of the case will soon reveal if any disorder other than thyroiditis be present.

PROGNOSIS.—Although the prognosis is influenced by the nature of the causative disorder and the development of complications, acute thyroiditis itself, without abscess, rarely proves fatal. The suppurative cases, however, show a greater mortality, owing to the complications—laryngeal edema, hemorrhage, sepsis, septic pneumonia, etc.—that may be awakened. Where it occurs as a complication of a general infection, it increases, of course, in proportion with its severity, the danger of a lethal ending.

TREATMENT. — Prophylactic measures during the acute stage of any infectious disease capable of causing acute thyroiditis should not be neglected. The thyroid should be watched and if it becomes sensitive or swollen **cold compresses** should be applied over it, and **saline solution** be either administered internally or per rectum and retained as long as possible to favor absorption. The absorbed solution, by reducing the viscosity of the blood coursing through the organ, favors resolution.

[As I have pointed out, the main cause of the lesions in the thyroid is the excessive proteolytic activity of the thyroidal blood, owing to the fact that the organ is the source of a substance which corresponds with Wright's opsonin—a view now sustained by several experi-

menters. The bacteria are thereby sensitized and prepared for destruction by phagocytes and the plasmatic antibodies; but when this process becomes excessively active, owing to the presence of a multitude of bacteria, the delicate tissues of the organ are themselves sensitized and subjected to proteolysis. Hence the miliary abscesses, which are in reality minute areas subjected to autolytic destruction. **Cold**, by reducing the proteolytic activity—due to ferments—of the antibodies in the organ, reduces the damage done; while **saline solution**, by reducing the viscosity of the blood and facilitating osmosis, also reduces its digestive power. C. E. DE M. S.]

Another pernicious factor in this condition is a high blood-pressure. Vascular depressants (**chloral hydrate** shown by J. C. Wilson to be helpful for this purpose in scarlatina) may be used with advantage. The tincture of **veratrum viride** may also prove useful. Care should be used lest too great depression be produced. Absolute rest is imperative. Suppuration calls for an exploratory incision and evacuation of the abscess. The multiplicity of small abscesses sometimes demands removal of the affected area. According to Kocher, the presence of a fistula points to extensive necrosis of the organ.

Treatment depends upon the underlying cause. If the condition develops in the course of rheumatism, **salicylates** are indicated; in the course of malaria, **quinine**. **Ice** may be helpful to the pain. The internal use of iodine preparations is especially to be avoided. In one case in which during convalescence syrup of the iodide of iron was given a severe recurrence was observed. Suppuration always calls for operation. In some cases acute thyroiditis precedes the development of Basedow's disease. Dunger (Münch. med. Woch.; Woman's Med. Jour., April, 1909).

Edema of the glottis should be met by the local application of a 10 per cent. solution of **cocaine** and a 1:2000 solution of **adrenalin**, equal parts, and if this proves insufficient the edematous tissues should be incised with the curved bistoury, duly protected, to near tip of the blade. If the pressure of the inflamed organ on the trachea is such as to threaten suffocation, **intubation**—or if the pressure is too low to be reached by the tubes, **tracheotomy**—is indicated. **Partial thyroidectomy** sometimes becomes necessary.

No one who is suddenly brought face to face in the middle of the night with the patient suffering from acute suffocating goiter can doubt that efficient treatment is not always so easy as we should like it to be. No one who has had to remove a deeply seated goiter from behind the sternum of a patient who is in imminent danger of suffocation can doubt that the operative difficulties of thyroid surgery may be very considerable. All these have happened to the writer. James Berry (Lancet, May 3, 1902).

Case of acute suppurative thyroiditis with pressure symptoms in a child 3½ months old. The disease followed a cervical adenitis, which suppurated and was incised. About three weeks after this there was a pneumonia, during which the thyroid gland began to swell, the condition being accompanied by fever and dyspnea.

To relieve the intense dyspnea an **intubation** tube was introduced, which gave immediate relief. About a week later the swelling of the thyroid, which had become largely localized to the isthmus, was opened, and about an ounce of thick, yellow pus was evacuated. The child made an excellent recovery. F. S. Meara and R. S. Macgregor (Arch. of Pediatrics, Aug., 1906).

ACUTE STRUMITIS.

Acute strumitis, *i.e.*, acute inflammation of a goiter, may be caused by the invasion of bacteria and their toxins, brought to the goiter by the circulating blood in the course of various infections, particularly those which are seemingly benign: tonsillitis, laryngitis, bronchitis, and ulcerative nasal disorders, enteritis, etc.; though as in acute thyroiditis, the more serious disorders—typhoid fever, diphtheria, lobar pneumonia, polyarthritis, puerperal sepsis, bacillary and amebic dysentery, Asiatic cholera, and other infections—may likewise provoke it, chiefly toward their close. Pathogenic bacteria seem to have an affinity for cysts and degenerated nodules. Traumatisms, punctures, even such as are practised when therapeutic agents are injected into a goiter, may also cause strumitis. It has also been ascribed to poisons, constituting the form known as “toxic strumitis.”

SYMPTOMS.—Acute inflammation in a goiter manifests itself by a sensation of discomfort in the mass and a chill, soon followed by local pain, and marked sensitiveness to pressure. Then appear fever, headache, and the most distressing symptom of strumitis: dyspnea, sometimes threatening asphyxia. This is due to pressure of the swollen goiter upon the trachea, or to impaction of the mass between the sternum and the trachea, complicated often with edema of the larynx.

Case in a woman of 50 who for years had had goiter. The first symptom was dyspnea, which was relieved by ice packs. The thyroid was found greatly swollen, however, the next day when stridor returned. The tumor was hard, did not fluc-

tuat. On laryngoscopic examination the arytenoid fold was seen to be very edematous. The thyroid was removed and during the operation a portion of it was found tightly packed under the sternum. When this was shelled out the breathing was immediately relieved and recovery was uninterrupted. The specimen showed a hematoma in the thyroid. London Correspondent (Med. Rec., Dec. 10, 1910).

Dysphagia may also be marked and painful, each bolus in passing along the esophagus exerting pressure upon the inflamed gland. Radiating pains in the neighboring structures up to the occiput or down the arms, owing to pressure of the inflamed growth on nerves, is sometimes complained of. Hoarseness is frequent from the same cause, or as a result of glottic edema. If no pus be present, the inflammation tends promptly to subside.

When suppuration occurs the fever may assume the hectic type with exacerbations and severe malaise and prostration. When this occurs in connection with a general infection, the prognosis of the latter may be markedly aggravated.

Case of strumitis which occurred in a goitrous man of 52. Croupous pneumonia having appeared suddenly, four days later the thyroid began to swell perceptibly. The dyspnea reached almost asphyxia, while the pain in the neck steadily grew worse. Exploratory puncture of the thyroid revealing pus, this organ was incised and irrigated. A diastolic murmur was audible all over the heart, the pneumonia cleared up, and he died. The autopsy showed abscess of the thyroid gland, malignant verrucose endocarditis of the aortic valve, a tumor and anemic infarct in the left kidney, and hyperplasia of the splenic pulp. The temperature did not fall after operation. Schlander (Deut. Zeit. f. Chir., April, 1901).

The inflamed goiter may become elastic and fluctuate if the abscess is large, which is often the case in strumitis. It may rupture into the surrounding tissues, open into the trachea, esophagus, the larger vessels, or, again, burrow down into the mediastinum, the lungs, pleura, etc., with its attendant dangers, or upward along the sheaths of the great cervical vessels. It may, however, open externally, to the great relief of the patient. Occasionally a small abscess is absorbed.

Case of strumitis in a woman of 50 who had a goiter for 25 years, which had never caused any disturbance. After an attack of dysentery, a large tumor developed suddenly in the thyroid with a fistula into the esophagus. The tumor grew so large it threatened suffocation. Some relief was obtained when pus was expelled into the esophagus. The writer incised and drained the tumor, finding calcareous degeneration in part of the thyroid. After the patient had recovered from this he resected the left lobe of the thyroid, the seat of the tumor, and there has been no further trouble since. F. Luz (Brazil Medico, Mar. 10, 1917).

DIAGNOSIS.—The only condition with which the strumitis may be confused is malignant growth, when softening, suppuration, and cachexia are prolonged. The course of cancer is not as rapid, however, and cultures and examination of fragments of the growth will usually establish the identity of the condition present.

Case of suppuration in a parenchymatous goiter simulating malignant disease in a male 63 years of age admitted to hospital with a swelling in the neck which had been present for nine years, but which had increased rapidly during the preceding few weeks. There was very severe pain up the right side of the

neck and at the back of the head. A large tumor extended from near the lobule of the ear to the sternum, and the trachea was pushed to the left. In removal a pus pocket was opened from above and a second accumulation surrounded a process of the tumor, which was found to extend into the anterior mediastinum. The tumor proved to be a parenchymatous goiter, acutely inflamed, and in a state of diffuse suppuration, with fetid pus. Recovery was quite satisfactory, but eight weeks after operation the right cord was still a little sluggish. Gilbert Barling (Birmingham Med. Rev., Nov., 1905).

PROGNOSIS.—The progress of the morbid process is governed by the intensity of the infection. Suppuration invariably prolongs the case, but if the abscess can be reached and evacuated the acute symptoms promptly subside.

A persistent abscess or a collection of them entail the dangerous phenomena enumerated above, which may cause death. Surgical measures, therefore, are indicated to save life.

TREATMENT.—The treatment is precisely the same as that recommended for acute thyroiditis, viz., **cold compresses** locally, and **saline solution** by the mouth or rectally to reduce the viscosity of the blood coursing through the organ. **Chloral hydrate** or **veratrum viride** used with care is advantageous to reduce the congestion of the organ, the former also acting as an analgesic by favoring sleep.

If symptoms indicating suppuration occur, the **abscess** if single, which is more frequently the case in strumitis than in acute thyroiditis, should be carefully located and evacuated. Kocher advocates **excision** of the goiter in such patients, if the sur-

rounding tissues are not involved in the suppurative process. The operation should be preceded by an **exploratory puncture** and examination of the fluid, pus, etc., contained in the organ to ascertain that the bacteria therein, particularly the colon bacillus or the staphylococcus albus, are non-virulent. The pus should first be removed by **aspiration** and an antiseptic solution injected into the cavity. When the abscess has extended to the surrounding tissues, the sphacelous areas should be opened with the galvanocautery and the pus evacuated, but excision of the goiter would not be a safe procedure. The evacuation of the abscess should be done with due care, and the cavity washed out to remove all pus, rather than cleared with the curette or with the finger, which may provoke dangerous hemorrhage, as in a case observed by Bonney.

CONGENITAL GOITER, OR GOITER IN THE NEWBORN.

Congenital goiter is relatively frequent in the newborn and is often fatal, owing to pressure on the trachea, nerves, and blood-vessels of the cervical area.

In a series of 50 cases of congenital goiter studied by the writers, death occurred at birth, or shortly after, in 60 per cent. If the child lives, the tendency is for the tumor to diminish in size. Planchu and Richard (*La Pathol. infant.*, July 15, 1907).

Congenital goiter is relatively frequent. Demme, in 642 cases of goiter, found 37 in the newborn and 59 in infants from 2 to 12 months of life. Diethlin, in 2292 cases of goiter, observed the condition in 25 cases during the first year. Richard found 43 cases of really congenital goiters. Thévenot reported 130 cases. M. Ch. Gonnet (*Revue men. de gynéc.*,

d'obstét., et de péd.; Surg., Gynec., and Obstet., Oct., 1909).

In some cases the goiter is purely congestive, owing, probably, as during parturition, to pressure upon the infant's neck, especially in face presentations and when forceps are used. It may also be due to persistence of the fetal circulation, but in most instances is of the parenchymatous type and is inherited.

Demme, in 53 cases of congenital goiter, found that in 37 of the 53 one or both parents suffered from goiter. In 23 cases the mother alone was affected.

Richard, in 43 cases of congenital goiter, found the condition of goiter in the mother 22 times and once in both father and mother.

In the 17 cases reported at Lyons, a goiter was found both in mother and child in 8 instances. Three generations have been known to have had the disease. M. Ch. Gonnet (*Revue men. de gynéc., d'obstét., et de péd.; Surg., Gynec., and Obstet.*, Oct., 1909).

In 6 cases witnessed by the writer, the mothers were all goitrous. In one case the mother and grandmother were goitrous; in another the mother and two of her sisters were goitrous. In a third case there was a history of infection in the family. One child was born dead; one baby died two days after birth; one died two years after birth of bowel infection. Two were living when last heard from; another, 18 years old, was goitrous. Mooney (*Arch. of Ped.*, Dec., 1910).

The goiter develops in such a way in some cases as to encircle the trachea and sufficiently compress it as to prevent respiration, constituting what has been termed in France the "constrictive goiter." It may also include the esophagus in its grasp, insinuating itself behind it, even though

appearing but slightly or not at all externally.

SYMPTOMS.—Death may occur almost immediately after a few efforts at respiration. Many are born prematurely, or are stillborn. Or, the infant shows signs of asthma, reaching in some instances to intense dyspnea with cyanosis, the child's cry being shrill or rasping. Death may occur suddenly immediately after the cord is ligated. When the goiter is due to simple congestion of the thyroid from compression or any other cause during parturition, or to screaming or writhing, it may disappear within twenty-four hours, never to recur in some cases; more frequently, however, it reappears intermittently. Dysphagia due to pressure upon the esophagus is not infrequent, the infant, in some instances, refusing to nurse. The clinical signs, with the exception, perhaps, of a slight swelling of the front of the neck, may not appear until several weeks or more after birth.

The writer observed a case in a child born at the end of the seventh month. There was no history of goiter either upon the paternal or maternal side of the family. The mass extended as high as the ears and filled the entire space between the jaw and the clavicle. A portion appeared to be substernal. The trachea was entirely surrounded by the tumor and was compressed laterally to a slight degree. The esophagus was so compressed that a No. 8 urethral bougie could with difficulty be passed. Microscopically the goiter was found to belong to the vascular variety. Hewetson (*Brit. Med. Jour.*, March 21, 1903).

The goiter may sometimes be felt, but in most instances it is quite small, and only discernible when the head is thrown back to stretch the neck.

Infant 1 week old who at birth was in a state of apparent death. After being resuscitated by energetic treatment there were great dyspnea, noisy respiration, and retraction of the ribs. No nourishment could be taken. Pollosson discovered a tumor in the neck so small that it was not easily detected. It was uncertain whether it was the thymus gland, a hemorrhage into a cyst of the thyroid, or a goiter. A median incision was made, and a fairly large goiter, which dipped deeply backward, was found. The tumor was pulled outside the wound by gentle traction (**exothyropexy**), and the dyspnea ceased at once and did not return. Genevet (*Lyon méd.*, Oct. 29, 1899).

PROGNOSIS.—When the goiter is due to congestion from pressure, which may be suspected after face presentation or forceps cases, the prognosis is good, particularly if measures calculated to sustain oxygenation are resorted to. In true congenital goiter prompt surgical procedures will alone save life when the growth is of sufficient size to cause pressure symptoms.

TREATMENT.—The main aim is to restore respiration and sustain it. The various forms of **artificial respiration** (see DROWNING, TREATMENT OF) with **oxygen** inhalations are very helpful. If, notwithstanding efforts in this direction, dyspnea recurs and persists, **section of the isthmus** or **exothyropexy** should be performed. The relief is immediate. Tracheotomy should never be resorted to; it is often followed by bronchopneumonia, hemorrhage, or other complications. **Intubation** has been recommended by some authors.

One hundred and thirty cases were found on record by the writers. The symptoms are practically the same as

in adults. Section of the isthmus or **exothyropexy** gives good results. It not only relieves the threatening compression of the air passages, but leads to the retrogression of the goiter. J. Fabre and L. Thévenot (Revue de chir., June 10, 1908).

In the congestive type **cold compresses** to the neck and **warm foot-baths** or **hot baths** tend greatly to reduce the swelling of the gland. In parenchymatous goiter which does not threaten life **thyroid gland**, 2 grains (0.13 Gm.) twice daily, administered to the nursing mother, causes gradual disappearance of the goiter in both mother and child in some instances. **Sodium iodide**, 5 grains (0.3 Gm.) three times daily, may be given instead if thyroid cannot be taken. A weak **iodine ointment**, rubbed gently into the goiter daily, avoiding cutaneous irritation, is also helpful. The tincture of iodine should not be used.

Pregnant women with goiter should be treated in the same way to arrest the possible development of a goiter in their offspring, and to prevent complications.

Case of a young woman suffering from a goiter who became pregnant for the fourth time. The swelling in her neck had been present for some years, but had caused her little inconvenience at former confinements. For the last five months of the present pregnancy her neck had been gradually increasing in size; it measured 46 cm. For two months she had suffered from dyspnea and cardiac palpitations; at the time of admission she had air hunger and was cyanotic; her condition was poor, respiration 48, pulse 120, no exophthalmos present. Both lobes and the isthmus of the thyroid were enlarged, the swelling extending below the border of the sternum. The heart was much enlarged; no mur-

murs were observed, but there was slight edema of the lungs. She was delivered without the use of instruments. Tracheotomy was considered, but, as she breathed more easily after delivery, it was not performed. Her condition suddenly became worse and she died a few minutes afterward. The autopsy proved that the operation would have proved useless, her death being due to the cardiac condition. Morgan (Bull. Lying-in Hosp., City of N. Y., March, 1906).

CHRONIC GOITERS.

These have been divided into various forms, based upon their pathological characteristics. For practical purposes, however, as previously stated, we will adopt a clinical classification calculated to establish a line of demarcation between goiters which are amenable to medical treatment and those which should be treated surgically.

Beginning with the earliest or incipient forms, we will use the term *diffuse non-toxic goiter*, but in keeping with personal views to be presently discussed these will be designated as the *hypothyroid type*, in which iodine, thyroid gland, etc., are indicated, to distinguish it from *toxic or the hyperthyroid type* or larval Graves's disease (*q.v.* in the present volume), in which such agents are harmful. The second series will be considered under the term *nodular benign goiters*, which include the *colloid*, *fibrous*, *cystic*, and *intra-thoracic goiters*, and also the *malignant goiters*, and, in addition, *goiters of accessory glands*, in all of which surgical procedures are indicated.

DIFFUSE NON-TOXIC GOITER (HYPOTHYROID TYPE).

To convey what I mean by this term, the following personal conception of the distinction between a non-toxic and toxic goiter must be introduced:—

Not all thyroid glands (including their parathyroids) are functionally equal. A perfectly normal gland is able to fulfill its protective function in any kind of infection or intoxication without undergoing perceptible enlargement. But we know that morbid hereditary influences weaken this organ, as they do all others, and also that various infantile diseases, diphtheria for instance, tend to produce focal hemorrhages in the thyroid and parathyroids and to inhibit, seriously sometimes, their functional efficiency. Now, if either one of the various causes of goiter, the many kinds of intoxication I have enumerated under etiology, occurs in an individual possessed of such a *debilitated* gland the organ reacts, but insufficiently, so as to meet the needs of the moment. Though spurred on, it is unable to oppose successfully the toxemia, and, owing to this excessive and abnormal excitation (through the action of the poison on its centers), it swells, thus forming a goiter. Such goiters very rarely show hyperplasia or hypertrophy of the tissue elements, as long as they remain non-toxic, but only evidences of excessive functional activity, especially hyperemia.

Conversely, in a *toxic* goiter, *i.e.*, one of the *hyperthyroid* type, we are not dealing with a debilitated gland from the start, but with a gland which was normal when a toxemia or a shock produced hypersensitiveness of its centers and caused it to become overactive. A previous debilitated gland may also, however, reach the stage of hyperplasia and hypertrophy, and thus assume the condition of hyperthyroidism, and begin to show symptoms of Graves's disease, tachycardia, tremors, etc., when subjected sufficiently long to abnormal activity, that is to say, when the cause

is not removed before the inception of the Graves phenomena.

SYMPTOMS.—In the typical non-toxic hypothyroid type the enlargement of the thyroid may be the first symptom noticed, and through, as a rule, undue tightness of collars previously worn without discomfort. As the goiter develops, it remains soft and diffuse, showing, perhaps, a tendency to grow larger on one side, usually the right. If the case is examined carefully, however, symptoms of hypothyroidism will be discerned, some of which the patient will recall as antecedents of the goiter. Hypothermia is the rule, though rarely marked. Bradycardia occurs in all cases, the pulse ranging from about 62 to 40 beats a minute or even lower. There is a marked tendency to hyperidrosis, especially of the extremities, excessive sweating occurring under the least exertion and sometimes without it. The feet and hands are apt to be cold, however, and the patient may complain of rheumatic pains, particularly in the occipital region. In keeping with this symptom-complex of hypothyroidism, the urea excretion is more or less reduced, usually about one-third. There are no pressure phenomena, dyspnea, dysphagia, etc., unless the goiter is of long duration, *i.e.*, has been given time to assume the chronic type, with surgical intervention as only resort.

The shape of the gland is not materially modified at first in this form, and any increase in size can only be discerned by palpation, though inspection may elicit a local enlargement during deep respiration, deglutition, and coughing, owing to the up-and-down movements of the growth. A diffuse goiter grows in all directions, the two lobes meeting medially unless the isthmus

takes part in the morbid process, as is frequently the case. The neighboring muscles are either raised or moved aside, according to their relative position. The growth also covers the trachea, but this canal is only compressed when one side of the growth becomes much larger than the other, causing dyspnea. This is not severe in simple diffuse goiters, as a rule, when the tumor is not hard, and is apt to occur only on exertion. Compression and displacement of the vessels are also rare unless the tumor be very large. We may then witness slight symptoms to vascular obstruction: headache, vertigo, etc.

Murmurs may be heard in the dilated blood-vessels, the latter projecting more or less from the surface in some cases, while the growth itself may be seen to pulsate. Pain does not occur unless a local inflammatory process in the goiter, *i.e.*, strumitis, is present. Unless the gland be inflamed or the growth be a malignant one, it can be moved freely in the tissues surrounding it and from side to side.

DIAGNOSIS.—The diagnosis of the non-toxic type of goiter is not difficult when the typical signs of hypothyroidism—which should always be sought—are present. Such, however, is far from being always the case. A relatively recent development of the goiter and the absence of tachycardia or other symptoms of hyperthyroidism, on the one hand, and bradycardia and a low temperature, on the other, serve to eliminate Graves's disease. The total absence of tenderness or pain serves clearly to differentiate it from any acute inflammatory process or a malignant goiter. From the chronic goiters, parenchymatous, colloid, or cystic, it is distinguished by its relatively recent onset,

the absence of pressure symptoms and of nodules, or evidences of fibrous degenerations elicited by palpation.

From the standpoint of treatment, the most important condition from which it should be diagnosticated is the *hyperthyroid* or *toxic type* of goiter, which is nothing but larval exophthalmic goiter, or hyperthyroidism. As stated above, it is readily distinguished by the tachycardia, tremor, and other symptoms of this disease.

PROGNOSIS.—Although the non-toxic hypothyroid goiter sometimes recedes of its own accord, especially in young patients and in pregnant women, its tendency is to persist if the cause is not removed. Though apparently benign, it is a pernicious form in the sense that in the child it tends toward the production of cretinism and in the adult to hyperthyroidism; or on the other hand, it may lead to myxedema, owing to its tendency to undergo colloid, cystic, fibrous, or other retrograde changes. It is probably the initial disorder in most cases of cretinism, and, in fact, of practically all non-malignant disorders of which goiter is a symptom.

PATHOGENESIS.—The presence of typical signs of hypothyroidism clearly indicates that we are dealing with a toxemia in a subject whose thyro-parathyroid apparatus, through congenital or acquired insufficiency, while capable of carrying on its antitoxic functions under normal conditions, is unable to do so when an excess of toxics occurs in the blood. This is due either to inability to produce a sufficiently active secretion or to the absence of the constituents, iodine especially, necessary to the elaboration of the latter. Stimulated to inordinate, though unproductive, and probably exhaustive,

activity through central stimulation by the poison, the glands become markedly hyperemic, the thyroid, owing to its size and location, becoming more or less enlarged, *i.e.*, goitrous. If the cause, the toxic, whatever that may be, is removed, or if iodine or thyroid gland is administered, the gland recedes and disappears. If nothing is done the morbid process progresses and chronic goiter results.

It is probable that at least a proportion of cases of thyroid enlargement in the course of pregnancy belongs to this class, the excess of waste products from the fetus acting as pathogenic factor.

When the growth progresses without interruption, and the conditions causing it are not removed, it undergoes various structural changes we have enumerated, each of which will now be reviewed. They may all be classed as:—

NODULAR GOITERS.

Non-toxic Type.—The great majority of nodular tumors represent a combination of the various forms of goiter, and are designated according to the predominant alteration.

Considered as a whole, nodular goiters develop in one or several parts of the gland and differ in this respect from the diffuse non-toxic goiter, which involves all parts of the organ. The affected areas may be the seat either of an increase of follicles, vessels, etc., a true hypertrophy, or of accumulations of more or less thick and tenacious colloid, which dilates one or more follicles. These areas, especially when a single nodule is present, tend to degenerate, owing to the influence of the proliferated tissues upon the neighboring structures and upon the local vascular supply, and to become the seat of hemorrhages.

Nodule of the isthmus is relatively frequent, the mass projecting from the middle of the neck. Nodular goiters tend to grow rapidly, and seldom yield to internal measures.

As goitrous masses may develop anywhere in the gland, and simultaneously in several parts of the organ, while varying greatly in shape and size, the pressure effects they produce vary greatly with each case. The trachea may be displaced from side to side, twisted, or compressed against the spine, thus producing dyspnea; the cervical vessels and the vagus may also be pressed upon, causing congestive disorders of the brain, syncope, slowing of the pulse and dyspnea. Hoarseness and aphonia may occur, if the recurrent laryngeal is pressed upon. Occasionally sympathetic nerves are compressed, thus giving rise to vascular phenomena or paralysis in the parts which these nerves supply.

Examination into the pathology, both gross and microscopic, of all the thyroid glands now in the laboratories of the Mayo clinic which have been removed from patients on the "exophthalmic goiter" list from Jan. 1, 1905, to Jan. 1, 1912, a total of 1208 exophthalmic thyroids, and also all the thyroids now in the laboratory removed from patients on the clinical "simple goiter" list from Jan. 1, 1905, to June 1, 1913, a total of 2356 simple goiters.

In the "exophthalmic goiter" list 79 per cent. are true exophthalmics, 21 per cent. are toxic non-exophthalmics, and in the "simple goiter" list 17 per cent. are toxic non-exophthalmics and 83 per cent. are non-toxic.

Practically all cases of clinically true *exophthalmic goiter* showed marked primary hypertrophy and hyperplasia of the parenchyma of the thyroid gland. Furthermore, the clinical stage of development of the disease

is parallel by the stage of development of the pathological condition in sufficiently marked degree that one may estimate the clinical condition from the pathological examination with about 80 per cent. of accuracy. The degree of severity of the clinical condition is similarly parallel by the pathological condition of the gland. The relationship between hypertrophy and hyperplasia of the thyroid gland and the clinical symptoms of true exophthalmic goiter is remarkably constant.

While mild degrees of hypertrophy and hyperplasia within physiological limits may be present in the thyroid gland, particularly in the young and during pregnancy, yet the absence of this condition in the thyroids of adults coming to operation for toxic non-exophthalmic and non-toxic goiters is most striking. Without making any allowance for either clinical or pathological errors of diagnosis, less than 1 per cent. of all cases coming to operation for goiter show any considerable primary hypertrophy and hyperplasia of the parenchyma of the thyroid except as associated with clinical symptoms of true exophthalmic goiter.

Eleven per cent. of all the thyroids on the "*simple goiter*" list showed as their principal pathological change a secondary regeneration of atrophic parenchyma. L. B. Wilson (Jour. Amer. Med. Assoc., Jan. 10, 1914).

Development of a nodule from either inferior horn, the growth growing downward, gives rise to a form of goiter known as **intrathoracic goiter**. At first remaining above the suprasternal notch it finally passes down into the thorax, behind the sternum, being aided in doing so by the downward movement of the thyroid and the suction of the enlarged organ into the chest, which occur during inspiration. It is apt to be met in subjects who, owing to their occupation, are obliged to bend the head forward, as in writing, during prolonged periods

each day, and in short-necked individuals. As the intrathoracic goiter develops, tending as it does to become very large, the resistance of the sternum causes it to compress markedly the structures on either side of the trachea and the latter itself, and may become a cause of sudden death.

Transposition of the thymus and lower poles of the thyroid when forming possibly act as one of the causes of intrathoracic substernal goiter. These growths usually consist of diffuse colloid or encapsulated adenoma, and when completely detached from the thyroid they are wandering. Most of the symptoms occur from pressure upon the circulation, the trachea, the nerves, or the esophagus. These tumors are usually associated with an ordinary goiter, and probably one-half of them are discovered through complications arising during a thyroidectomy. As they are often enucleated with great difficulty, their removal may be followed by severe hemorrhage. C. H. Mayo (Surg., Gynec., and Obstet., March, 1910).

Intrathoracic goiter is by no means a rare disease, but is one in which the diagnosis is apt to be very difficult without the aid of the X-rays. The most important symptoms are dyspnea, palpitation of the heart, difficulty in swallowing, cough, hoarseness, stridor, redness and turgidity of the face, cyanosis of the lips, dilatation of the veins of the neck and of the upper anterior part of the chest, dullness over the manubrium sterni, and a deep position of the larynx. These symptoms together particularly favor the diagnosis of an intrathoracic goiter when they cannot be explained by conditions of the heart or lungs, or the presence of a goiter in the neck. There are other intrathoracic goiters that give rise to no troubles, but are revealed by the X-ray examination. These cases should not be considered as unimportant, as the patients are

predisposed by its presence to diseases of the respiratory and circulatory organs. Kreuzfuchs (N. Y. Med. Jour., from Münch. med. Woch., Jan. 3, 1911).

A nodular mass may grow in such a way as to pass behind the trachea and encircle and constrict it, constituting a dangerous variety known as **constrictive goiter**. It may also be due to embryonal malformation of the organ, both of its superior horns encircling the trachea or esophagus.

Nodular goiters are in most instances accompanied by symptoms of hypothyroidism, but are seldom reduced to any material degree by iodine or thyroid gland, owing to the overgrowth of interstitial fibrous tissue, cysts, etc., of which they become the seat. The organ being gradually destroyed as a functional entity, through these degenerative changes, there may develop cretinism, if the goiter begins in early childhood, and myxedema, if the growth occurs in the adult. In most instances, however, enough of normal tissue remains in the organ to carry on its functions, this being aided by the formation of new secretory follicles.

Colloid Goiter. — This form of goiter, which is often met with in practice, is thus termed because its main characteristic is an accumulation of thick, tenacious colloid in follicles of the organ, in isolated lobules, lymph-spaces, and even the whole organ. In the average case the gelatinous colloid (the growth being termed *struma gelatinosum* by some authors) so overfills the follicles that the goiter is lobulated and hard. It is probably an advanced stage of the softer goiters, both diffuse and nodular, and may be distinguished from them through their relative hardness, and the fact that they do not

become reduced under pressure with the hand, owing to escape of a part of the fluids into the neighboring tissues, as do some of the softer growths. This form of goiter is not influenced by internal medication, iodine, thyroid, etc.

Fibrous goiter differs entirely from the foregoing pathologically in that it is due to the development of fibrous tissue, a result of local inflammation in various parts of the organ. It is, therefore, hard under pressure and nodular. The glandular elements being more or less compressed by the fibrous tissue, their functional power is inhibited, causing a corresponding degree of hypothyroidism, which, when advanced, may reach the stage of true myxedema. In some cases the goiter becomes as hard as wood; hence the terms **ligneous goiter** and **Riedel's disease** sometimes attributed to it.

Sclerotic or ligneous goiter: Riedel's disease. In 1896 Riedel published a description of 2 cases of a condition to which he gave the name "eisenharte strumitis," and in subsequent years observations of a similar nature were recorded by the same writer and by others, bringing the total number of cases up to 17. The commonest age, however, is during the fourth decade. More than half the recorded cases have been in men. A distinctive feature is the rapid evolution of the disease. In a few months, or even weeks, a tumor develops, which produces serious effects by compression of the trachea and the recurrent laryngeal nerves; the laryngeal palsy is accompanied by dangerous paroxysms of dyspnea. On the other hand, it is unusual to find any evidence of pressure on the sympathetic nerves or upon the esophagus. The tumor is diffuse, involving the whole gland; it is extraordinarily hard and firmly fixed to surrounding structures. Its surface is smooth and does not adhere to the skin. The neighboring lymph-glands

do not show any striking enlargement. To the naked eye the diseased area appears whitish and homogeneous; it is very hard to cut. Microscopically nothing is found except a free formation of dense fibrous tissue of an inflammatory type. X. Delore and H. Alamartine (*Revue de chir.*, July 10, 1911).

Case of Riedel's disease. The patient was a young man who had noticed a slow enlargement of the neck for one and a half years previously. This was attended by gradually increasing dyspnea, stridor, and dysphonia. A very hard, dense, painless swelling of both lobes of the thyroid was noted. At operation the thyroid was white, hard, and densely adherent to the surrounding structures. Both lobes and the isthmus were removed; the compression of the trachea, however, was not relieved until some dense connective-tissue bands in front of it were separated.

Myxedema developed subsequent to the operation, which was controlled by thyroid substance. Microscopic examination showed a profound fibrosis. The fibrosis of Riedel's disease differs from that associated with myxedema by the fact that the connective tissue penetrates the capsule. G. R. Murray and F. H. Southam (*Lancet*, May 4, 1912).

Cystic Goiter.—This form may develop from a colloid goiter or from an *adenomatous goiter*, a form in which the glandular epithelium is embryonic and produces but little colloid. It may be composed of retention cysts or of *hemorrhagic cysts* due to rupture of some dilated vessels in the growth. This constitutes a special form of goiter, which is treated below.

Cystic goiter is lobular, sometimes oval, at others circular, but always circumscribed. It is elastic, and usually soft and smooth. Fluctuation may sometimes be elicited.

SEMIMALIGNANT OR MALIGNANT TYPES OF GOITER.

The above constitute the series of benign goiters in the sense that none of them show the characteristics of cancer, unless it be as a complication as specified in the forms just described. But it must not be forgotten that practically all malignant growths of the thyroid gland are preceded by a benign goiter. The following types may be, or are, malignant from the start:—

Goitrous accessory glands, especially those lying between the trachea and esophagus or behind the esophagus, may become the seat of malignant tumors and cause correspondingly grave pressure symptoms. Others lying between the hyoid bone and the aortic arch, and which resemble lymph-glands, may also be the seat of goitrous development, occasionally malignant.

Lingual goiter is an interesting, though rare, form of goiter which is more frequent in women than in men, though in the latter accessory thyroids are more common. When they become goitrous this occurs with relative suddenness, the growth showing great vascularity. Lingual thyroids are situated upon the dorsum of the tongue behind and below the foramen cecum and are sometimes very large. They cause prolonged fits of coughing, deglutition, spasms, and hoarseness. Malignant growths in this situation are painful, *sarcoma* growing more rapidly than *carcinoma*. The gland may also be the seat of benign growths, *dermoid cysts*, *calcareous deposits*, *gummata*, etc. It is essentially a surgical disorder.

Malignant goiter may occur as a primary carcinoma or sarcoma of the

gland, but in most instances it appears as a complication of a parenchymatous goiter of long standing. The *diffuse malignant adenoma*, due to changes in the follicles similar to those observed in adenoma elsewhere, is a rare form which, owing to its lobulated surface, resembles the diffuse colloid. But its tendency to recur after removal shows its malignant nature.

The occurrence of pain in a pre-existing goiter, if it cannot be traced to a strumitis, is suggestive of malignant changes, especially if the cachectic facies is present. The surrounding lymph-glands are involved relatively early. While metastases seem to show a predilection for the osseous system in carcinoma of the thyroid, sarcoma tends to spread to the neighboring tissues of the neck, trachea, etc.

Case of struma maligna with copious bleeding of varices of the esophagus in a woman of 58. The goiter increased rapidly in size; she had repeatedly vomited blood which in the beginning was of a dark color, but after the hemorrhage had continued for a time became bright red. The thyroid tumor had grown to be very large, reaching from the lower part of the larynx, down the neck and along the sternum, the lower border being found at the xiphoid process. Death occurred, and at the post-mortem it was found that the tumor had grown through the sternum, destroying the greater part of this bone. The first rib on the left was involved. H. Hellendall (Deut. med. Woch., April 6, 1899).

Case of a woman 48 years of age who from girlhood had had a goiter. Shortly before coming under observation she noticed a slight increase in difficulty in swallowing, and previous to this time had had severe pain in the left hip and thigh. This was so severe that she became almost

maniacal. Upon examination the left inguinal region was found slightly infiltrated and the left leg was adducted and rotated inward. It was freely movable at the hip, but all extension was painful. A diagnosis of malignant tumor of the thigh was made.

Gradually the patient grew worse, the goiter increased in size, and death occurred. At the autopsy a tumor of the thyroid gland was found and also one in the left thigh. Microscopically these tumors were found to be spindle-cell sarcomata. The primary tumor was in the thyroid, and metastasis then took place to the thigh, because these tumors usually give such metastasis; it was diffuse in the thyroid, circumscribed in the bone, and there were metastatic nodules in the medullary cavity beyond the tumor-mass. Wagner (Münch. med. Woch., Sept. 2, 1902).

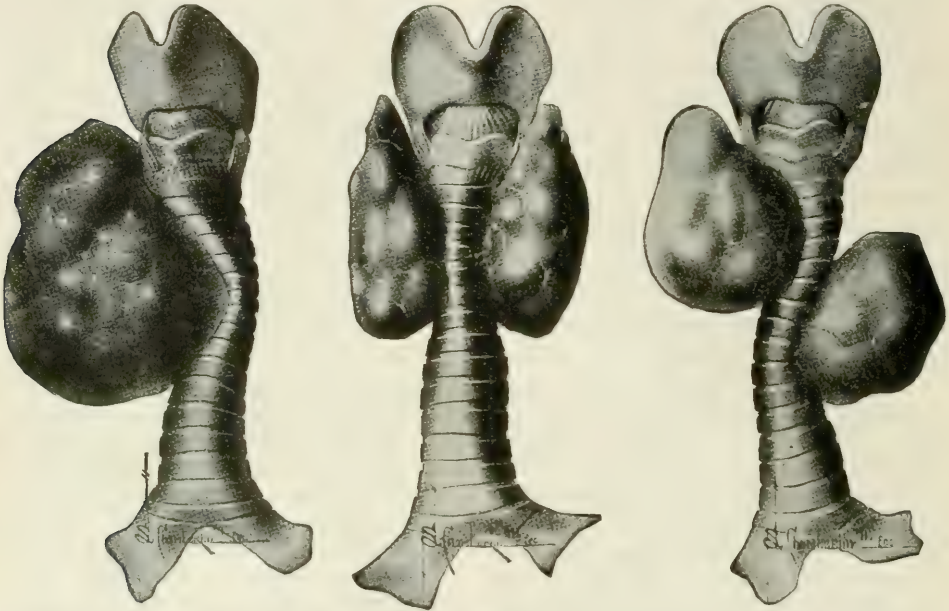
Of 173 cases of malignant goiter 14 (8 per cent.) showed tracheal involvement, and 7 (4 per cent.) involvement of the esophagus. The trachea is most frequently attacked from its posterior aspect—that portion of it not protected by a cartilaginous skeleton. Intratracheal vegetation soon takes place, and perforation follows, resulting in a tracheoesophageal fistula. The symptoms of tracheal invasion are dyspnea, wheezing, cough, slight hemoptysis, and later on convulsive attacks of dyspnea and suffocation, especially if the intratracheal growth is pediculated. Esophageal invasion causes dysphagia, partly of mechanical and partly of nervous origin, from compression of the vagi, hemorrhages from the esophagus, and the regurgitation of glairy mucus, sometimes blood-stained. C. Viannay and L. Pinatelle (Revue de chir., vol. xxix, No. 3, p. 429, 1904).

SPECIAL SYMPTOMS.—Certain symptoms occur only when the goiter has become sufficiently large to interfere with the functions of neighboring

structures and their circulation and nervous supply.

Dyspnea is a prominent symptom of goiters that have reached sufficient size to compress either the trachea, and thus interfere directly with respiration, or the blood-vessels of the neck and neighboring structures, thus disturbing the circulation and the equable return

goiter. Hemorrhages occur in all kinds of goiters, most frequently in the colloid and cystic varieties. The blood-vessels in goiters are delicate and thin, so that from the slightest cause they are torn and lead to hemorrhage. The clinical symptoms result from the sudden increase in volume and the consecutive narrowing of the trachea. Pain and tenderness develop from the tense swelling.



Distortion of trachea produced by nodular goiters, the isthmus being removed. Partly schematic. (Kocher.)

of blood to the heart and lungs; or it may compress the recurrent laryngeal nerve.

There occur cases in which the dyspnea sets in suddenly and terminates fatally, like lightning out of a clear sky. The writer reports the case of a man who had a small goiter which previously had not given him the slightest disturbance. After firing several shots from a gun, in consequence of the recoil, the goiter suddenly increased in size and gave rise to considerable disturbance of breathing and of the circulation. Operation later established the presence of a small hemorrhage in the

The sudden arrest of the current in the cervical veins, and, therefore, in those of the goiter, from severe attacks of coughing, in cases of tracheal and bronchial catarrh, gives rise to an internal pressure that ruptures the delicate vessels in the goiter. Severe muscular exertion or blowing on a cornet may produce a similar effect. External violence, direct or indirect, may give rise to the hemorrhages. When a patient with goiter is suddenly taken with an attack of "goiter asthma," it may be due to an acute catarrh of the bronchial tubes, an acute inflammation of the goiter, or a hemorrhage into it.

Bruning (Archiv f. klin. Chir., Bd. xci, S. 614, 1910).

Case of a servant aged 24 who, following a fall from a car, soon gave signs of collapse and severe dyspnea, and died an hour and a half after the accident. At autopsy the thyroid, which was goitrous, was found to be the seat of a large hemorrhagic cyst. S. G. Champion and C. B. M. Aldridge (Brit. Med. Jour., July 15, 1911).

The dyspnea is increased by temporary hyperemia of the goiter, by conditions which increase the demand of air, such as exertion, and by local catarrhal inflammation due to the pressure. When the trachea is markedly compressed *tracheal stridor*, a loud, whistling sound, may be heard during both inspiration and expiration. Paralysis of the vocal cords is frequent.

Results of laryngoscopic examination in 1000 cases of goiter. About 95 per cent. of the patients were operated on, and were examined before and after operation. There were found 17 cases of paresis of both cords, 93 of the right cord, and 162 of the left in the total of 289 partial or complete paralyzes in 272 individuals of the 1000. Total paralysis of the right cord occurred 18 times; of the left, 30 times. Partial or complete abduction paralysis of the right occurred 50 times; of the left, 83 times. Partial loss of both motions of the right occurred 38 times; of the left, 62 times. Bilateral tensor paralysis occurred in 4 cases. The paralyzes were more frequent with enlargement of the right or left lobes. Goiter of the median lobe alone was seldom accompanied by affection of the cords. Paralysis occurred sometimes when the lobe was not palpable, and in some cases with tremendous enlargement there was no affection of the cord. In goiters of the same size the cords were affected more frequently in cases with lobes located near the clavicle, especially

if the goiter was wholly or in part intrathoracic. Firmness was likewise important, small, hard lobes being more likely to cause paralysis than large, soft ones. No cases of recovery from total paralysis after operation are recorded, but in cases of short duration or when edema is a factor there may be recovery. J. Matthews (Jour. Amer. Med. Assoc., Sept. 3, 1910).

Asphyxia may readily be produced in such cases by sudden violent exertion, bending the head in such a way as to increase pressure of the growth on the trachea, sudden pressure on the growth, constriction of the neck, violent cough; hemorrhage into the goiter, thus suddenly increasing its dimensions; swallowing the wrong way, anger, by causing turgescence of the cervical vessels, etc. Cyanosis is not necessarily a symptom of threatening asphyxia, since, as shown below, it is often caused by pressure on the veins of the cervical region.

Cardiac phenomena are frequent in goiter. The dyspnea is often increased by *dilatation of the heart*, due to the interference with the respiration referred to above. The heart should always be examined in these cases, since appropriate treatment is very helpful. Dilatation of the heart may also be due to pressure exerted by the goiter on the blood-vessels, and to the effects of the toxemia upon its muscular elements. Finally, when the goitrous morbid process is sufficiently advanced, the characteristic *tachycardia* of exophthalmic goiter with its other symptoms may also appear.

Of 68 cases the after-history of the patients is included; the mechanical influence of the goiter on the heart was evident in 65 cases; examination later showed that the heart seldom returned to normal after removal of

the mechanical influences. The heart had evidently felt the effect of the toxic action of the goiter to such an extent as to be unable to recuperate after its removal. The material reviewed confirms further the frequency of transition of a "thyrotoxic heart" into the complete syndrome of exophthalmic goiter. Blauel (Beiträge z. klin. Chir., March, 1909).

Among 895 patients with myogenic disease of the heart (651 men, 244 women) 121 had had evident goiter (21 men, 100 women); in 11 exophthalmic goiter was present; in 110 there was a goiter which had lasted many years and to which in the course of time a disease of the cardiac muscle had been added. While in the cases of exophthalmic goiter the disease had begun in early life, of the others 6 had begun to suffer between the ages of 20 and 30, 19 between 30 and 40, 27 between 40 and 50, 43 between 50 and 60, and 15 over 60. In 71 there was a myocarditis with concentric hypertrophy of the heart, with no signs of Basedow's disease; in 29 there was an acceleration of the pulse with arrhythmia; in 11 regular, greatly accelerated pulse; in 24 arrhythmia without great acceleration; in 7 attacks of tachycardia, with otherwise normal action of the heart. Gittermann (Berl. klin. Woch., Nov. 18, 1907).

Heart disturbances are common in simple goiter, but they differ from the usual forms of goiter heart. The main findings are an accidental systolic murmur, more pronounced over the pulmonary artery; an accentuated second sound, and slight enlargement of the heart dullness toward the left. The apex beat is normal, the pulse not accelerated, and there is not much subjective disturbance. These heart findings are due to thyroid intoxication. Bauer (Deut. med. Woch., Oct. 17, 1912).

Cyanosis is apt to occur when the veins which drain the head, neck, and arms are compressed by the growth. It is apt to be especially marked during

exertion. It affects chiefly the cheeks, lips, and tongue, and also the arms when the innominate veins are compressed. *Edema* of all these structures also occurs when the pressure attains a marked degree. The affected arm is sometimes raised with difficulty. *Headache, vertigo*, and other signs of congestion occur when the cervical arteries are compressed.

Pain occurs only in a goiter when it is the seat of inflammation (see STRUMITIS) or hemorrhage; in the latter case, however, it soon ceases. Malignant tumors are also the seat of radiating pain in most cases.

Hoarseness is frequently observed in goiters that are sufficiently large to cause distortion of the trachea, compression upon the cricoid and thyroid cartilages, thus interfering with the proper anatomical relations. Hoarseness may also be caused by pressure upon the recurrent laryngeal nerve, and by a chronic catarrhal process of the laryngotracheal mucous membrane, due in turn to the pressure and the interference with the functions of the epithelium through which the membrane is kept free of foreign substances, mucus, etc.

Paralysis of muscles of the arm, and *numbness* of the fingers, occasionally met with, are due to pressure upon the brachial plexus. These symptoms are mainly observed in intrathoracic goiter. *Irritability, nervousness, restlessness*, and other nervous phenomena may also be witnessed when hyperthyroidism is a feature of the case, which it is not in true goiter. *Insanity* is more frequent, however, in goitrous than in normal individuals.

The writers examined 4184 insane patients. In palpating the necks of these patients they were as thorough as possible. There were 270 dis-

tinctly palpable thyroids (goiters), 6.45 per cent. There were 2125 males with 48 goiters, 2.25 per cent., and 2059 females with 222 tumors, 10.78 per cent. The relation of goiter between males and females was then about 1 to 4 or 5. In these goiters the right gland was enlarged 101 times, and the left 24, thus making the relative proportion 1 to 5. There were 131 bilateral enlarged glands, and in these almost invariably the right gland was the larger. The middle lobe was enlarged in 12 cases. There were 244 simple, 20 fibroid, and 4 cystic goiters. Only 2 cases of typical exophthalmic goiters were found in this series. Leaving out a few types of insanity, comprising a small number of cases, dementia precox presented the greatest percentage of goiters and also the greatest number of insane. As the catatonic form of dementia precox had been considered due to thyroid disturbance, they expected to find the greatest number of goiters in this type; but they found that the hebephrenic form had 93 per cent. of the goiters. Next to dementia precox came involution melancholia and then the paranoiac state. Werelius and Rydin (Jour. Amer. Med. Assoc., Aug. 5, 1911).

Myxedema may supervene when the functions of the thyroid have been sufficiently inhibited by fibrous and other degenerative changes practically to arrest its functions. This complication is seldom witnessed, however, owing to the fact that a small portion of normal gland suffices to carry on its functions.

DIAGNOSIS.—Patients are frequently unaware of the existence of a goiter until the symptoms described under the foregoing general heading cause them to seek medical advice. This is especially the case when a diffuse goiter is present, the actual change being but a slight swelling of the neck, detectable only by means of careful palpation.

Some cases complain of the necessity of increasing the size of their collar-band; of disappearance of the normal circular creases of the neck; of stiffness about the front of the neck; of dyspnea on inclining the head forward, etc.

The goiter being connected through the posterior capsule of the thyroid with the trachea and esophagus, deep respiration and deglutition cause the growth to move up and down, a fact which greatly facilitates its detection by inspection and palpation. Cough accentuates the movement and is especially helpful in the diagnosis of intrathoracic goiters. Detection of the latter is further facilitated by percussion over the upper part of the sternum, when marked dullness is obtained. If the goiter is sufficiently large to cause pressure on the trachea, a sibilant or whistling râle may be heard on auscultation. This is apt to be mistaken for asthma in cases of intrathoracic goiter occurring in short-necked individuals.

The diagnosis of a goiter is a relatively simple matter even in incipency when the measures described above are carried out. From the diffuse non-toxic growths, nodular goiters are readily distinguished. While the former are, as a rule, diminished in size through pressure upon them, owing to the vascular depletion produced, nodular goiters, which include the various types classed under that heading, are firm, lobulated, and yield but little, if at all, to pressure. Fluctuation may sometimes be discerned in large colloid or cystic growths.

In so far as treatment is concerned, a distinction between the various types of chronic nodular goiter is important, since in practically every instance a gland which has undergone any marked

degree of degenerative change and which gives rise to pressure symptoms yields only to surgical measures.

The diagnosis between benign and malignant goiters is based mainly upon the more rapid growth of the latter. Malignant goiters are most often developed from pre-existing goiters, however.

A complication which sometimes leads to confusion under these circumstances is hemorrhage into the goiter, which occurs not infrequently, particularly if the mass has been subjected to traumatism, vascular strain, etc. The resulting enlargement is of temporary duration, however, while a malignant goiter continues to grow more or less rapidly. Sarcomata of the thyroid tend to extend to and to cause ulceration of the trachea and cervical tissues, whereas carcinoma tends to extend to the neighboring lymph-glands and to osseous tissues.

Enlargement of the accessory thyroid bodies can be identified only with difficulty if the enlargement corresponds, as to location, with one of the thyroid. As a rule, however, their abnormal location suggests the presence of accessory-gland goiters.

PROGNOSIS.—The prognosis of chronic goiter is always unfavorable if all the complications it may involve are taken into account. They start, as I have pointed out, *with a deficient gland as foundation*; while this gland may, under stress of stimulation, increase in activity, this process in time leads, when unchecked by appropriate treatment, to degenerative changes, fibrous, colloid, cystic, etc., which ultimately destroy its functional activity; cretinism in the child, or myxedema in the adult, then develops. Conversely, a goiter, though started by an insuffi-

cient gland, may, through stimulation and the resulting formation of new secretory follicles, exceed a normal gland in activity, and initiate a case of hyperthyroidism or Graves's disease.

Goitrous subjects are more liable than normal ones to insanity, particularly the depressive and puerperal forms.

Under appropriate treatment, *provided the causative intoxication is removed*, some cases of benign nodular goiter recover, especially in children and young adults. When, as in practically all fully developed cases, operative procedures are intrusted to fully competent surgeons, the mortality is practically *nil*.

TREATMENT OF CHRONIC GOITER.—In the treatment of goiter much depends upon the efficiency with which the primary cause, whether it be of fecal origin as in the waters of endemic areas, or the intestinal canal, or toxins from tonsillar, peridental, gingival, or nasopharyngeal abscesses, etc., is eliminated. This must be done thoroughly.

In contaminated districts no water should be used as beverage or for cooking or to wash edible foods, salads, fruits, etc., that has not been thoroughly boiled.

All operative removal of pyogenic or toxic foci must be thorough and radical.

Again, while compensative remedial measures—iodine, the iodides, thyroid, etc.—will prove efficient in practically all cases of diffuse or "parenchymatous" goiters met with in children or young adults when the organ, though enlarged, about preserves its shape or is somewhat larger on the right side,—which corresponds with the relative size

of the same lobe in normal glands,—it may prove hurtful in cases which have just reached the threshold of hyperthyroidism. The use of these agents should, therefore, be attended with considerable circumspection, until the case has shown itself to be one in which they are indicated. The onset of tachycardia and tremor indicates that the case is not an appropriate one for iodine or thyroid gland, and that, conversely, arsenic, for instance, which depresses glandular activity, or ligation of some of the arteries to the gland to reduce its functional activity should be resorted to.

The various remedial agents employed and their indications will now be considered in turn.

Compensative Agents in Atoxic Goiters.—By these I mean remedies which tend to compensate for the deficient secretion supplied to the organism at large by the thyroid.

First among these are **iodine** and the **iodides**. Although iodine was discovered in 1812, burnt sponge, which is rich in this halogen, had been the main remedy for goiter many centuries. Its mode of action suggests itself: it enhances directly or indirectly the antitoxic function of the thyroid apparatus or its secretion in the blood-stream, and thus aids in breaking down the causative toxic. As this relieves the thyroid gland of the excessive activity which causes it to enlarge, it recedes.

The **iodine** treatment and thyroid extract should be reserved for the cases free from stenosis, the goiter not growing rapidly, and the symptoms indicating deficient thyroid functioning. Here a rational and specific internal treatment gives as brilliant results as surgical treatment. T. Kocher (*Deut. med. Woch.*, July 11, 1912).

The best salt of iodine is **sodium iodide**, the potassium salt being harmful to the heart, owing to the action of the potassium ion on this organ. In appropriate cases, however, it should not be given in too small doses, except as test, since these only serve to enhance tissue metabolism and fail to go beyond, *i.e.*, carry on the antitoxic action. A dose of 5 grains (0.3 Gm.) may be given night and morning, then three times a day. If taken in the midst of a meal, dissolved in a small tumblerful of water, trouble will seldom be experienced. The dose may be gradually increased until 10 grains (0.6 Gm.) are taken thrice daily. The case should be carefully watched, and if any sign of iodism appears the use of the iodide should be discontinued temporarily and the smaller doses resumed.

The iodism may sometimes be controlled by administering, besides the iodide salt, arsenic in the form of **Fowler's solution**, beginning with 2 minims (0.12 c.c.) twice daily in half-glassful of water.

The **iodide** or **iodine** are also used efficaciously as prophylactic agents.

Out of 3872 school girls examined for thyroid enlargement only 43.59 per cent. were normal. To forestall thyrotoxic symptoms, **sodium iodide**, 2 to 4 Gm. ($\frac{1}{2}$ to 1 dram), was given over a period of a few weeks, administering 0.2 Gm. (3 grains) daily. This was done in May and December. Marine and Kimball (*Jour. of Lab. and Clin. Med.*, Oct., 1917).

At least 2 to 4 mg. ($\frac{1}{30}$ to $\frac{1}{15}$ grain) of **iodine** should be given to each person daily in experiments in goiter prophylaxis. Klinger (*Corresp. bl. f. schweizer Aerzte*, Apr. 27, 1918).

Soft, diffuse, atoxic goiters in young subjects yield readily to the **iodides**, particularly if signs of hypothyroidism are present, but nodular, fibrous, cystic,

and colloid growths are rarely influenced materially and should be treated surgically. In some of these cases, in fact, iodine and its salts, even in minute doses, sometimes cause considerable discomfort, thumping heart beats, weakness, etc. **Pure iodine, Lugol's solution,** and other preparations of iodine have been used, but the sodium salt gives the least trouble.

In anemic cases, **iron,** preferably **Blaud's pill** in small doses, should be given with the iodides.

The writer states that goiter is extremely prevalent in the Telemarken district in southern Norway, southwest of Christiania. In 1 school at Lunde 80 per cent. of the children have goiter, most of them being of the atoxic type, which nearly always subsided under iodine. He never noted symptoms of intolerance in children, but several adults developed symptoms of thyrotoxic action, and 1 girl of 15 seemed to have had her simple goiter transformed by the iodine into exophthalmic goiter, although the medication had been moderate and the intermissions long.

The dosage he prefers in colloid goiters is $1\frac{1}{2}$ grains (0.1 Gm.) **potassium iodide** every other day for 2 weeks, and then suspension for 3 weeks and resumption for 2 weeks, and so on. In parenchymatous goiters he anoints the goiter with an **iodine-potassium iodide** salve, using from 15 to 45 grains (1 to 3 Gm.) daily for 2 weeks at a time, then suspension for 3-week periods. An ointment is better than the tincture, sparing the skin.

When symptoms of exophthalmic goiter or other signs of excessive functioning of the thyroid are present, **sodium phosphate** in a 5 per cent. solution seems to give good results—a tablespoonful 4 times a day, in milk. The basis for this treatment is the antagonism between iodine and phosphorus in the action of the thyroid gland pointed out by Kocher. He has often seen the goiter subside under

this treatment, especially when the patient gave up work and went to the hospital. S. Kjolstad (Norsk Mag. f. Lægevidensk., Mar., 1918).

Injectations of iodine, iodoform, and other agents into the gland were at one time recommended, but they caused many deaths, as shown by Heymann, owing, as demonstrated experimentally by Horsley, to penetration of the agent used into the bloodstream. They should not, therefore, be employed.

Thyroid gland has been extensively used in the treatment of the same form of goiter—the atoxic, diffuse form—with varying success. It is especially useful when the iodine salt tends to produce iodism too readily to obtain the best results from it. From 2 to 3 grains (0.13 to 0.2 Gm.) of the desiccated thyroid may be given at night with a glass of water, and the heart beat closely watched. If it fails to increase more than ten beats, the dose may be increased to 4 or even 5 grains (0.26 to 0.3 Gm.) daily in an adult. Larger quantities during the twenty-four hours are seldom necessary; its use on retiring protects the heart, through the avoidance of exertion while the drug is being assimilated.

The effect of thyroid is the same as that of iodine, *i.e.*, it enhances the antitoxic power of the glandular secretion, thus compensating for the excessive activity of the organ, which then undergoes diminution in size. It is not, however, as reliable as the iodides, unless it be in incipient cases when prompt action is necessary. If untoward symptoms occur and these fail to cease on withdrawing the thyroid, **Fowler's solution** in 2- to 3- minim (0.12 to 0.18 c.c.) doses three times daily will soon subdue them, as stated above.

To enhance the action of these agents 4 per cent. **iodine ointment**, prepared fresh, or a 5 to 10 per cent. ointment of **iodopetrogen**, of the U. S. Formulary, should be rubbed over the gland, daily, ceasing as soon as iodism or irritation of the skin appears. A piece as large as a small hazelnut suffices if properly rubbed in.

An **ointment of biniodide of mercury**, a piece as big as a pea being rubbed into the goiter daily, favors its absorption.

Diagnosis and treatment of goiter based upon 1000 cases. Occurring most frequently in the female about the onset of menstruation, and disappearing around the twentieth year, the *goiter of adolescence* is symmetrical (thyroid-shaped), of moderate degree, and fairly firm in consistence. Generally there is only the one symptom of enlargement of the thyroid gland, though nervous patients complain of "an obstructive feeling in the neck." In treating these cases assurance can be given that it is physiological and in time disappears spontaneously. **Iodine internally and massage with the ointment of biniodide of mercury** will hasten absorption.

Analogous to adolescent goiter is the goiter of pregnancy, occurring with pregnancy and disappearing with parturition. It produces no symptoms and requires no treatment.

Colloid goiters roughly retain the general outline of thyroid gland, frequently extending over the chest, beneath the clavicles, sternum, and even posterior to the pharynx. The gland may be nodular, but is usually softer than the adolescent goiter. When symptoms of pressure develop, a **resection** is indicated. It should be freely exposed and palpated to prevent any one of its projections being left behind to continue the pressure symptoms.

Encapsulated adenomata occur singly or in great numbers, arising from any

part of the gland. They always have a definite outline. *Malignancy* of the thyroid gland almost always occurs in the adenomatous form of goiter. There is seen rapid growth, general hardness, early pressure symptoms, involvement of the neighboring lymphatics, and thyrotoxicosis. Clinically, the thyrotoxicosis of adenomata differs from that of exophthalmic goiter in that the nervous symptoms do not reach the same degree of intensity. Sometimes single adenomata, frequently overlooked, arise from the lower pole of either lobe and project posteriorly. They may sometimes explain an unaccountable heart lesion. The treatment of encapsulated adenomata is **surgical**, and the writer doubts if they are ever cured by medical treatment. In those occurring in young adults not wishing operation he prescribes, for daily **massage over the goiter**, the **biniodide of mercury ointment**, and also **Lugol's solution**, 3 gtt. *t. i. d.*, over a period of six months. E. H. Schneider (Dominion Med. Mthly., Jan., 1914).

In some cases all the foregoing measures fail. This is because the causative toxemia is perpetuated.

Where goiter is endemic, the toxic is probably a water-borne one, mineral or organic. Recent investigations have emphasized the influence of micro-organisms (Kocher, McCarrison, and others), fecal pollution (Susuki), and other contaminating agents. A **change of the water** used as beverage, cooking, etc., is therefore an important feature of the treatment. A diet rich in meats is also an indirect cause (Waters, Baumann) of goiter; liver, for instance, is known to produce goiter in mice and trout (Reid Hunt, Marine) when fed to them. A **meat-free diet**, to prevent any intestinal auto-intoxication it might sustain, is at times very helpful. The intestines should be kept open by **saline aperients**, prefer-

ably **sodium phosphate** 2 drams (8 Gm.) daily, and if any autointoxication of intestinal origin is clearly discernible, or if pathogenic organisms, entozoa in the alimentary tract be a possible cause, intestinal antiseptics: **thymol**, **betanaphthol**, **salicylate of sodium**, or **creosote carbonate**, should be administered.

In recruits suffering from parenchymatous goiter, which is extremely common at Basel, the writer obtained distinct reduction by giving 2 Gm. (30 grains) of **salol** a day, but only in simple follicular enlargement and parenchymatous goiter. He thinks that benefit from mild continuous purgation and disinfection sustains the theory of parasites in the drinking water as the cause of goiter. Messerli (*Revue Méd. de la Suisse Rom.*, Dec., 1915).

Pelvic disorders, especially if accompanied by ulceration; catarrhal disorders of the tonsils, ears, nose, or nasal sinuses, characterized by a purulent discharge, should also receive attention. Any form of toxemia may, in individuals in whom inherited or acquired hypothyroidism is present, initiate or perpetuate a goiter, and should therefore receive attention.

When the goiter fails to subside Watson's treatment, injections of **quinine** and **urea hydrochloride**, or Porter's method of injections of **hot water**, both of which are described in detail in the article on Graves's disease (under TREATMENT) in the present volume, may prove effective.

Suffocation in intrathoracic goiter may be combatted by head posture, **ice** to the neck, **morphine** or **codeine** for glottic spasm or a **general anesthetic** for incarceration. Kreuzfuchs (*Centralbl. f. d. Grenzgeb. d. Med. u. chir.*, Apr. 28, 1911).

Measures to Control Hyperthyroidism.—When a goiter is showing a

tendency to assume the Graves syndrome, **Fowler's solution**, 2 to 3 minims (0.12 to 0.18 c. c.), three times daily in half-glassful of water, or the **bromides** to reduce the sensitiveness of the centers; **cold compresses** over the gland are useful. A 5 per cent. solution of **sodium phosphate**, one tablespoonful four times daily is often useful.

If, on the other hand, tachycardia, tremors, etc., persist, the treatment for Graves's disease (*q.v.*) should be employed.

The X-ray Treatment.—Although a large number of authors have treated goiter by this means with apparent success, the observations of von Eiselsberg and others have demonstrated that such results do not, by any means, follow in all cases. Moreover, the method is attended with considerable risk to the patient, in that it produces intense hyperemia and muscular adhesions, which increase the danger when an operation becomes necessary.

A long list might be made of the authors who have treated goiter with **X-rays** with success. The writer does not think that the Röntgen treatment of goiter should be entirely abandoned. In many cases it has an undoubtedly good effect, although this may be only temporary. Especially is this the case when there is pressure on the trachea in patients who are inoperable on account of age, myocarditis, arteriosclerosis, and the like. It is just in these cases that the writer met with the best results. L. Freud (*Archives of Röntgen Ray*, June, 1910).

The **X-rays** offer a good prospect of cure without operation in a large percentage of cases of exophthalmic goiter. The principal treatment should be directed to the thyroid, but in many cases the thymus should also be rayed; this is major work and should not be attempted by any one

unfamiliar with the technique and the physiology of the ductless glands. The first symptoms of improvement are a decrease in the pulse rate and an increase in weight; the reduction in the size of the thyroid is not always marked even after the disappearance of all symptoms, and the exophthalmos is the last to show improvement. Russell Boggs (Interstate Med. Jour., Apr., 1917).

Surgical Treatment.—This will be described in the article entitled: THYROID, SURGERY OF. It is indicated when in diffuse goiters medical treatment proves unavailing; when in lobular growths there is progressive deformity and pressure symptoms; in intrathoracic goiters, and where there is evidence of malignancy. When the operation selected is performed by an experienced surgeon, the operative mortality is practically *nil*.

The main point taught by 1200 operations is to leave sufficient functionally capable tissue. Quality is of more importance than quantity, and it is necessary to keep from injuring the thyroid tissue during the operation. These 2 points render it necessary to avoid extensive operations on both sides. A. Kocher (Corresp. bl. f. schweizer Aerzte, Dec. 8, 1917).

PROPHYLAXIS.—Kimball, Rogoff and Marine (Jour. Amer. Med. Assoc., lxxiii, 1873, 1919) have reached certain conclusions concerning the prevention of goiter which they base on the examination of girls in the public schools of Akron, Ohio, from November 26 to December 3, 1918—19 months after beginning the prophylactic use of iodine. They administered 2 Gm. (30 grains) sodium iodide in 0.2 Gm. (3 grains) doses for 10 consecutive school days, repeated each autumn and spring. The results showed that simple goiter

may be prevented on a large scale and that the method is practical and economical and can be regarded as a public health measure in goiter districts.

The danger of iodism or of exophthalmic goiter from such amounts of iodine as were given is shown to be insignificant.

Klinger (Schweizer med. Woch., Jan. 6, 1921) also protected school children with tablets of sodium iodide in regions where goiter was endemic. No signs of intolerance appeared among the over 1,000 children who took the tablets even up to 16 months. The results demonstrated that school children could be kept from or cured of goiter by this simple means, taking 3, 4 or 5 mg. ($\frac{1}{20}$, $\frac{1}{16}$, or $\frac{1}{12}$ grain) of iodine in the week for part of the year.

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GOLD.—metallic gold is not official in the U. S. P. Only one preparation is recognized: *Auri et sodii chloridum* U. S. P. (chloride of gold and sodium), which is given in doses of $\frac{1}{30}$ to $\frac{1}{10}$ grain (0.002 to 0.006 Gm.).

The best vehicle with which to combine gold and sodium chloride in capsule is tragacanth or guaiac resin; neither of these decomposes it. The time for administration should be one hour after eating, or, better still, one hour before eating. The ideal method for administration is by hypodermic injection, the solution used being made with equal parts of distilled water and glycerin. Daniel R. Brower (Jour. Amer. Med. Assoc., Oct. 1, 1898).

PHYSIOLOGICAL ACTION.—The chloride of gold is a caustic irritant. In small medicinal doses the preparations of gold sharpen the appetite and promote digestion. If long continued, symptoms of overstimulation follow their use. Con-

stipation is usually present. The mental functions become more active. Increased venereal desires are attributed to the use of gold. In men priapism is not uncommon. In women the menses are increased.

POISONING BY GOLD.—The acute form of poisoning follows the ingestion of a toxic dose and manifests itself by a violent gastroenteritis, accompanied by cramps, convulsions, trembling, insomnia, priapism, and insensibility.

In the chronic form of poisoning by gold there develops a fever accompanied by sweating, a very abundant flow of urine, and salivation, without tenderness or ulceration of the gums, epigastric heat and oppression, headache, dryness of mouth and throat, with gastrointestinal irritation.

Treatment of Acute Poisoning by Gold.—The principles of treatment are the same as poisoning by corrosive sublimate. The contents of the stomach should be evacuated after the free administration of albumin, eggs, milk, and flour. External heat should be applied and stimulants administered by the mouth, the rectum, or by hypodermic injection. Morphine is useful if shock is present. Atropine will diminish the salivary secretion, and astringent (tannin) or dilute-acid mouth-washes will relieve the salivary symptoms.

THERAPEUTICS.—The preparations of gold are not as much in favor as formerly. Indigestion is relieved by small doses ($\frac{1}{60}$ to $\frac{1}{24}$ grain—0.0011 to 0.0027 Gm.) given three times daily. Mills regards it as a valuable tonic in hysteria and other disorders dependent upon depravity of the nervous system. Magruder has extolled its effects in pertussis.

Genito-Urinary Disorders.—In diseases of the internal organs associated with sclerosis, as nephritis, cirrhosis of the liver, etc., the persistent use of gold and sodium chloride has given excellent results. In contracted kidney a pill of chloride of gold has been recommended by Dana. It has been found of considerable value as a stimulant in impotence, and in the seminal emissions due to masturbation or general asthenia.

Phthisis.—Gibbs and Shurly, of Detroit, laboring under the impression that

gold and sodium chloride possessed bactericidal powers in this disease, reported a number of cases in which satisfactory results were obtained.

The writer treated 5 cases of pulmonary tuberculosis, free from fever and other complications and with doubtful prognosis, with intravenous injections of potassium and gold cyanide by the method recommended recently for lupus. The initial dose was 1 c.c. (16 minims) of a 1 per cent. solution, thoroughly diluted with saline solution. A therapeutic effect is undoubted, yet it is generally better to employ much smaller doses, which give rise to no temperature elevation. Junker (Münch. med. Woch.; Charlotte Med. Jour., Dec., 1913).

Syphilis.—In old secondary and tertiary cases where mercurials and the iodides have been long in use, gold will yield beneficial results, as in gummata, syphilitic pharyngeal ulcerations, specific ozena, etc. Ingals has found gold chloride valuable in syphilitic laryngitis. Hale White finds the gold and sodium chloride preferable to corrosive sublimate in the tertiary form, especially when the osseous system is involved.

Effusions.—Gold has yielded good results in ascites due to chronic hepatitis, post-scarlatinal dropsy, and in ovarian dropsy.

Gynecological Disorders.—Amenorrhea, sterility due to coldness, ovarian torpor, and the tendency to habitual abortion have been benefited by the use of chloride of gold.

Mental Disorders.—Good results have been obtained from the use of gold in melancholia and hypochondria accompanied by depression. Vertigo, when due to gastric disturbance, is often relieved by small doses of gold chloride, but when cerebral congestion or plethora is present, the use of gold is contraindicated.

Inebriety.—Chloride of gold has been recommended in the treatment of chronic alcoholism but mainly by empirics. W.

GONORRHEA. See URINARY AND GENITAL SYSTEMS, SURG. DISEASES.

GONORRHEAL ARTHRITIS.

See RHEUMATISM, GONORRHEAL.

GONORRHEAL OPHTHALMIA.

See CONJUNCTIVA, DISEASES OF.

GONORRHEAL RHEUMATISM.

See RHEUMATISM.

GONORRHEAL VAGINITIS.

See URINARY AND GENITAL SYSTEMS.

GOUNDOU (Anakhre, Henpue, or Big-nose) is a tropical disease peculiar to negroes, characterized by the development on each side of the nose below the eyes of osseous growths rounded in shape. At first there is severe headache, a sanguino-purulent discharge, and a slight bean-like swelling which forms the basis of the growth. As the latter increases, it may interfere with vision simply by obstructing its field; it may also at this stage compress the nostrils and interfere with respiration. The tumors themselves are painless and the overlying skin remains normal.

Case of goundou, a rare condition of the face. Though noticed in Africa occasionally, this is the first case reported in Brazil. All cases occur in negroes. In this case, a mulatto aged 24, the tumor was found just on the left side of the nose, spreading over the superior maxillary bone. It grew painlessly, and he remained perfectly well. The bony outgrowth was scraped off, and he is again in good health. Pathologically it showed the characteristics of an osteoma. The author considers it a trophic nervous lesion, an hypertrophy of the jaw-bones, found only in descendants of the colored race. Mendes (*Revue de Chir.*, Oct., 1901).

ETIOLOGY AND PATHOLOGY.—

Goundou has been ascribed to many different causes: a sequel of yaws (Chalmers); a disease *sui generis* (Braddon); a trophic neurosis (Mendes); an example of atavism in the negro (Strachan); malformation due to the non-union of the nasal and frontal bones (Kleng); the presence of the larvæ of insects in the nostrils (Maclaud). According to Wellman, none of the explanations proposed rests on any-

thing more than conjecture. The tumors are doubtless a hyperplasia, probably an osteoplastic periostitis due to a definite but undiscovered cause.

TREATMENT.—Medicinal treatment is useless, but surgical removal of the growths is readily effected and is not followed by recurrence. S.

GOUT. —SYNONYMS.—Podagra; arthritis urica.

DEFINITION.—Gout is a constitutional disease due to an excessive accumulation of uric acid and other purin bodies in the blood and tissues, manifesting itself in various ways and attacking various tissues and parts of the body, but most frequently the articulations. It occurs in an acute and a chronic form, both of which are characterized by the deposit of urates in the affected parts. Another form is called calcium gout. Both may be of neurogenic origin.

An excess of calcium in the blood alone can lead to deposition of calcium in healthy organs, as shown by Tanaka, and in many cases of calcium metastases in skeletal diseases of man without nephritis. This, however, is uncommon in man, for usually there exists a nephritis. On the other hand, extensive calcification may occur in some parts of the body, without increase of the calcium contained in the blood, through resorption from the bone; in such cases there is usually, but not always, a nephritis. When necrosis is found after dissolving the calcium, the writer believes it is the result of the deposition calcium, not the cause. The name "calcium gout" is therefore appropriate for the condition described. M. B. Schmidt (*Deut. med. Woch.*, Bd. xxxix, S. 59, 1913).

SYMPTOMS.—An attack of acute gout may occur without any precursory symptom in persons who, before, felt quite well; but this mode of development is not usual. Generally,

premonitory signs are experienced some time in advance, especially in the digestive and circulatory system and in the kidneys. The patients have frequently led a luxurious life; have been accustomed to excessive consumption of food, especially of animal food; have indulged in alcoholic drinks, and taken little or no exercise. They are often obese, with red and flushed face, and complain of heartburn, sour eructations, flatulency, and other indications of a dyspeptic derangement. Another form of gout—poor man's gout—is met with in persons living badly and exposed to cold and dampness; these patients are ordinarily lean, with sallow faces.

Immediately before an attack of acute gout the dyspeptic symptoms become aggravated; the bowels are obstinately confined; hemorrhoidal pains and hemorrhage are observed. The patients complain of headache, vertigo, drowsiness; sleep is disturbed by pain or cramps in the calves and elsewhere; there is pain in various articulations, paresthetic sensations, such as numbness of the fingers, chilliness, etc.

Irregularity of the action of the heart is often observed and the pulse is ordinarily firm and tense; the morbid state of the nervous system manifests itself by mental depression, irritability, bad temper; severe neuralgia is a frequent precursory symptom, and severe pains of the lumbar region are frequently complained of. In spite of all these manifestations, the appetite is generally good and the venereal desire is frequently increased. The urine is in most cases concentrated and scanty; in others the micturition is free, acid, and

abundant, the urine being clear and watery. Just before the attack all the precursory symptoms commonly disappear and a general sense of well-being may be experienced.

Although some of these precursory symptoms are observed in most cases, an attack of gout may well occur without warning; when the first attack sets in, the patient may believe that he suffers from a sprain of the affected joint or that the pain is of rheumatic nature and only by repetition of the attack does the real nature of the disease become apparent.

In the majority of cases of acute gout the metatarsophalangeal joint of the great toe is the articulation first attacked, generally on one side, but sometimes on both; in subsequent attacks other articulations become involved, either of the foot (podagra) or of the hand (chiragra). Almost all articulations may successively or simultaneously be affected, even the articulations of the jaw and of the spine; the hip-joint and the shoulder-blade are very rarely affected.

The attack itself has been vividly described by Scudamore, Sydenham, and other classics of gout: "The patient has gone to bed without any particular disturbance of health and often feels better than for some time; after some hours' sleep he is awakened, ordinarily between 12 and 3 o'clock, by a very intense pain in the great toe. The attack sometimes begins with a slight rigor. The pain soon increases to complete agony; there is much restlessness, and in vain some relief is sought by changing the position of the foot. The patient complains of extreme tension and throbbing in the affected joint; the pain, which has been compared to

that caused by a tightly drawn thumb-screw, is aggravated by the slightest touch or vibration, and becomes so intense that nothing at all like it occurs in any other joint disease.

"After some hours of this excruciating pain, some relief is obtained, coming gradually or quite suddenly, perspiration occurs, and sleep follows. On the following day the affected joint is found swelled, red, tense, shining, and tender. Some pain continues all the day, and toward evening it becomes aggravated, reaching almost the same intensity as in the preceding night." The temperature is somewhat elevated; it reaches 102° F. (38.9° C.), but seldom higher; the pulse varies from 80 to 100.

For some days the symptoms may recur in the same manner, then some edema appears around the affected joint, and successively increases to the fourth or fifth day, when the pain finally commences to decline; the swelling of the affected joint then diminishes, and this is commonly followed by cracking and peeling off of the cuticle: a process accompanied by intense itching. When the great toe-joint or similar small articulations are affected no effusion in the joint can be felt; when larger articulations, such as the knee-joint, are attacked, this sign is frequently observed.

During the attack there is commonly thirst, but no appetite; the patient feels even aversion to solid food, and some nausea; vomiting occurs rarely; the tongue is furred and the bowels constipated, or there may be some pale and offensive stools. The urine is scanty, concentrated, and a copious sediment of urates and uric acid crystals is precipitated.

When the attack has passed away, the patient often feels better than before it; some weakness, tenderness, and stiffness of the affected joint remain for some days; then complete recovery is established. The duration of the whole attack varies from six to ten days, and may even reach some weeks; in that case there are numerous remissions and exacerbations of the attack.

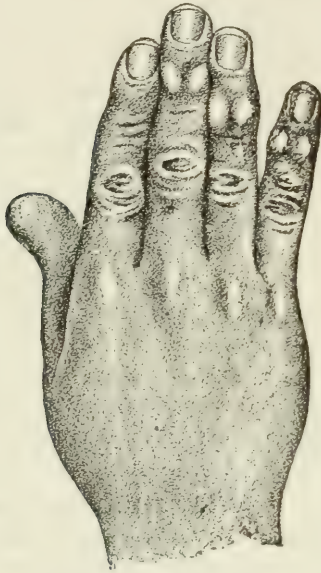
All attacks of acute gout do not, however, pass off suddenly; they may supervene gradually and increase in severity until they reach the true classical form. Sometimes the first attack is more violent, but as the malady progresses the accesses become more prolonged and are not so painful; at first the attack generally comes on once a year,—in the spring; then twice a year,—in spring and autumn; afterward at more irregular intervals. Only rarely does the malady show itself by one attack only; that may occur when the patient alters his whole manner of life, renounces the use of alcoholic stimulants, lives on very frugal diet, etc.

As the attacks become more frequent, asthenia increases, the pain is less violent, the duration of the access is longer, the stiffness of the affected joints does not completely disappear, and they remain enlarged, red, and tender even after the attack has passed away; smaller or larger hard nodules (tophi) are found in the tissues around the joints and elsewhere,—the case is passing over into the chronic stage.

As already stated, the first attack of acute gout ordinarily affects the metatarsophalangeal articulation of the great toe; in some cases the knee or the elbow-joint is attacked at the

onset. Garrod and other authors state that an injury, such as a sprain or a contusion, may determine the localization of the gouty process to the injured joint. Chârcot observed that the articulations of paralyzed extremities were particularly liable to be involved by gout.

Chronic Gout.—Chronic gout may occur as the result of a long series of acute attacks which gradually have



Gouty fingers. (Pfeiffer.)

weakened the constitution of the patient, or it may appear in feeble subjects as the only manifestation of gout. In both cases the joints successively get enlarged, deformed, stiff, —even immovable,—nodulated, owing to the deposition of urates in their structure. The skin covering them is congested and thin, with large, blue veins; ultimately it may rupture, and discharge whole chalky masses of urates,—tophi,—sometimes followed by suppuration and ulceration. The deformities of hand and foot are caused by partial dislocations of the

phalanges, with deflection of the fingers in various directions; when the affected articulations are moved, a scraping sound is heard and felt. In the most advanced cases not only fingers and toes, but also wrist and elbow, ankle-joint, and knee, are stiff and deformed, and at last the patient may be obliged to remain immovable in his chair or in his bed as an impotent cripple.

In chronic gout urates may be deposited in different structures, such as tendons (especially the tendo Achillis), bursæ, aponeuroses, and periosteum; in the cartilages tophi may be found, very frequently in the ear, but also in the eyelids and on the nose. These tophi are generally of the size of a pin's head or a bead; at first they contain a whitish fluid containing crystals of urate; ultimately they become solid and form small, hard nodules.

In the skin tophi are more rarely found, but have been observed in the face. The urine in chronic gout is ordinarily pale and watery, sometimes slightly albuminous, and commonly abundant; it contains always casts of renal tubuli, hyaline or granulated. The patients are weak and pale, suffering from disorders of digestion; they are subject to cramps, neuralgias, and other nervous disorders.

Irregular Gout.—Besides the symptoms directly dependent on or associated with the deposition of urates in the articulations and in other structures, many morbid symptoms have been observed in the course of gout and have more or less correctly been named symptoms of irregular gout; these symptoms may alternate with the regular attacks, and their

gravity is frequently in inverse proportion to the violence of the true gouty attacks. Symptoms of irregular gout may occur,—an imperfect development of the attack, or suppressed gout; or when inflammation of the joint from some cause or other (improper treatment) unduly subsides, retrocedent gout.

Almost all internal organs may become the seat of disorders which have been ascribed to gout.

The gouty kidney presents the same signs as the ordinary granular-atrophic kidney, and cannot be dis-

pression, epileptic fits, and apoplectic attacks. All kinds of neuralgia, especially gouty sciatica and costal neuralgia, have been described, and symptoms of disorders of the spinal cord and the meninges and paresis or paresthesia at the peripheral nerves have also been noted.

The vascular disorders are generally caused by atheromatous changes of the large vessels and followed by hypertrophy and fatty degeneration of the heart. Severe palpitations, intermittent and irregular cardiac action, and weak, very slow or rapid



Gouty fingers. (Pfeiffer.)

tinguished from it, neither by the symptoms nor by the anatomical examination. It will be shown later on that a certain degree of granular atrophy of the kidney is found in all cases of gout; when the renal changes are fully developed, the urine becomes clear and watery, contains urea and uric acid and in deficient quantity, and the patients may die from renal insufficiency. Gouty persons often suffer from gravel and calculosis; oxaluria is frequently met with; chronic cystitis and urethritis may be observed, especially in old persons suffering from gout.

In the direction of the nervous system many symptoms of morbid derangement may be observed, such as headache, hemicrania, vertigo, fainting, sudden delirium, mental de-

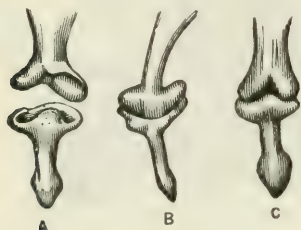
pulse are frequent symptoms in gout. There may be dyspnea and a feeling of constriction, and true attacks of angina pectoris are not uncommon. Phlebitis, especially of a recurrent form, has been observed among the symptoms of gout by competent observers.

Although the digestive system is very commonly deranged, the stomach and the bowels are not liable to specific gouty changes; fatty liver and a tendency to cholelithiasis are frequently observed; severe pain in the stomach or in the bowels may occur, but these seem to be of neuritic origin.

There are groups of symptoms in gout which certainly have no connection with uric acid. They include dyspepsia, skin diseases, myalgia and

neuralgia, arteriosclerosis, and granular atrophy of the kidney. These and other phenomena observed suggest that the disturbance in the purin metabolism is not the true essence of gout, but is merely one symptom of a more general disturbance. W. His (*Deut. med. Woch.*, April 15, 1909).

In chronic gout, in the absence of acute symptoms, and with patients on a purin-free or nuclein-rich diet, there is no profound change in the intermediary metabolism as compared with that of a non-gouty person. These negative findings do not exclude the possibility that in gout there is (1) a disturbance in the metabolism of the nucleins, (2) or a disturbance in some other phase of the intermediary metabolism, (3) or a



Osseous enlargement in gout. *A* represents the phalanges from the back, and *B* the side view. For purposes of comparison a delineation is given of the dorsal surface of a normal phalangeal joint,—shown in *C*. (*Pfeiffer*.)

disturbance in some minor phase of intermediary metabolism due to nuclein foods. Wentworth and McClure (*Arch. of Int. Med.*, Jan., 1918).

The skin is frequently affected. Among the diseases of the skin allied to gout may be named erythema, eczema, urticaria, psoriasis, prurigo, and acne.

Bronchitis and asthma are often met with in gouty patients; there seems to be a certain antagonism between gout and tuberculosis; at least, it has been asserted by many authors that tuberculous changes develop very slowly in gouty patients.

Obesity and diabetes mellitus are often associated with gout. Uratic

deposits have been found in the cornea and conjunctiva; uratic keratitis and iritis and gouty inflammation of the vitreous body have been observed.

When uratic deposits occur in the mastoid cells or in the cecum tympani they may cause deafness.

Rhinitis and parotitis urica have been mentioned, and also xerostomia, *i.e.*, extreme dryness of tongue and mouth lasting for months. Throat inflammations and esophagismus have likewise been noted.

The urine of gouty patients is of varying aspect and nature; in persons disposed to gout the urine is ordinarily concentrated, loaded with urates, and a sediment of urates and uric acid is deposited; during the gouty attack the urine presents commonly the same character. In other cases the urine is pale and watery; there is diminution of its principal components, and traces of albumin may be found. In "poor man's gout" and in chronic cases which have weakened the constitution of the patient the watery, pale urine is frequently observed.

From the investigations of Vogel, Schmoll, Laquer, and Magnus-Lévy it appears that before the attack and in the free intervals between them nitrogen is constantly retained in the body, whereas during the attack this is reversed, urea and also uric acid (His, Pfeiffer) being excreted at this period in quantities even exceeding the normal.

As already mentioned, a slight albuminuria may be occasionally found; but even if that be not the case, symptoms of a disease of the kidneys are never failing in gout. One of us examined many samples of urine from gouty patients and found that

by the use of a centrifugal apparatus and a microscope we were always able to detect hyaline and granular casts in it, and are of the opinion that this indication of a morbid state of the kidneys is a constant symptom of all stages of gout.

DIAGNOSIS.—The diagnosis of a typical attack of gout is easy not only as regards the localization of the morbid process, but also as to the development of the affection. Chronic gout may be confounded with other chronic affections of the joints of gonorrheal, tuberculous, or neuropathic origin. Generally the diagnosis is facilitated by the clinical history of the complaint and by the examination of the affected articulation. In acute gout there are the unmistakable symptoms produced by an attack of podagra; in chronic gout the presence of tophi in the joints, ears, forearms, and other parts of the body will lead to the diagnosis.

Study of familial eosinophilia has cleared up the conception of the gouty and the neuroarthritic diatheses, asthma, urticaria, etc. These are all the result of a constitutional abnormal condition of the vegetative nervous system. This is manifested usually by a constitutional and familial eosinophilia. It may be further manifested by asthma, hay-fever, urticaria, epilepsy or gout, these being all clinical equivalents in adults; children are liable to present the exudative diathesis. Asthma and hay-fever, as well as gouty joints, are thus explained as a nervous-gouty catarrhal state. The acute attack of gout is an acute trophoneurosis. The most serious localization of the gouty tendency, however, is in the kidneys, and this adds, secondarily, a new element to the pathology of gout, namely, retention of uric acid. The mistake has been made that this uricacidemia is assumed to be the cause of gout, when

in fact it is secondary to the neuroarthritic diathesis. The retention of uric acid sets up a vicious circle between the attacks of gout; urticaria may result as an equivalent of the acute attack of gout. In the intervals between the attacks of gout, if the elimination of uric acid is below normal, we can assume that the kidneys are already more or less pathologic. Asthma, hay-fever and gout are more common in men than in women, possibly because the *thyroid* seems to function less in the male. In women the gouty tendency becomes more manifest at or after the menopause, when the thyroid may be supposed to become less active. Falta's report that the elimination of uric acid is usually low in exophthalmic goiter fits into the argument. Klinkert (Jour. Amer. Med. Assoc., from Nederl. Tijdsch. v. Geneesk., Dec. 8, 1917).

It is often difficult to distinguish between the chronic gouty affection of a joint and the morbid change caused by rheumatoid arthritis,—or, as it is more properly called, the polyarthritis deformans,—which disease attacks the cartilages, as well as the bone, and leads to destruction of the cartilage, to proliferation and thickening of the ligaments, and frequently to growths of osseous protuberances. In this malady there is no trace of uratic deposits.

The chief points of difference between gout and polyarthritis deformans are the following: In gout hereditary predisposition is commonly observed; the disease occurs more frequently in the better classes than among the poor; it is most prevalent among males; in the clinical history there is often a record of abuse of alcoholic stimulants, beer, or strong wines; the patient may suffer from lead poisoning.

In many cases the appearance of

gout has been preceded by repeated attacks of renal colic or by long-continued evacuations of uric acid sand in the urine.

Frequently (but by no means always) gout begins with an acute attack; tophi may be found on the external ear or elsewhere. The urine is usually found deficient in urea and uric acid by treating it in the centrifugal apparatus, while by examination of the sediment with the microscope, casts of the tubuli, hyaline or granular, will always be detected in quantities more or less great. After the discovery of Röntgen the X-rays have been used as a diagnostic means; various investigators, especially French, have demonstrated that the uric acid compounds offer no resistance to the X-rays. In a Röntgen photogram of a hand or foot affected by gout the clear lines between the bones indicating the articulations appear quite unaltered, and the extremity resembles very much a healthy extremity and differs only from it by the enlarged outlines of the fingers and toes. Greater deposits, such as tophi, are quite invisible in Röntgen photograms. The reproduction of a hand or foot affected by polyarthritis deformans presents quite a different aspect; all the articulations affected by the disease, even if it be not developed far enough to cause stiffness or enlargement of the joint, have lost their clear, transparent appearance, and are of an obscure, almost black color. When the joint has been affected for some time, it is absolutely impossible to discern the exact place of the articulation, the bones seem soldered together, and that even in cases where a rather good mobility of the articulation still exists.

A number of cases encountered confirm the writer's idea that in rheumatism, aside from all the cases with known or probable etiology, such as trauma, inflammation, acute rheumatism, and infections, there are a large number of cases in which the arthritis must be regarded as the manifestation of some general cause not localized in the joints. This applies particularly to Heberden's nodes, whose connection with gout and diabetes has long been known, although they may develop without either. This characteristic form of arthritis is so unmistakably independent of external causes that some endogenous injury must be accepted for all cases. The disturbance in the purin metabolism is peculiar to gout and has nothing to do with chronic arthritis. It is important to differentiate the two, and Röntgen examination may aid, especially when the joints are deformed; gouty tophi cast no shadow. In dubious cases the criterion is the elimination of purin or examination of the blood for uric acid after four or five days of purin-free food. This differentiation is important on the practical grounds that severe chronic arthritis induces a tendency to cachexia and phthisis. It is purposeless and harmful to restrict such patients to a purin-free diet. W. His (*Deut. med. Woch.*, April 15, 1909).

In spite of the imperfections of the early Röntgen technique, Hubner made out clearly the bubble-like cavities in the phalanges of the fingers, which he considered were filled with uric acid salts. There is no doubt that at this early date Hubner recognized and correctly interpreted the typical appearance of gouty alterations of the bone as seen in the Röntgen picture. Ten months later, in the *Comptes-rendus* for 1897, there appeared an article by Potain and Serbanesco on the same subject, and four months afterward another by Oudin and Barthélemy. They both agreed with previous observers that the appearance was not

due to atrophic changes, but to the substitution of urates for the natural phosphates of the affected bone, the urates being of much less density, and therefore much more transparent to the X-rays. A. Koehler (*Arch. of Röntgen Ray*, Feb., 1912).

The writer relies in the diagnosis, mainly upon the presence of tophi, and on the characteristic uric acid curve during an attack. High uricemia, low endogenous uric acid output, and delayed elimination of exogenous uric acid, etc., are either ambiguous or not distinct enough to be decisive. Weinberger (*Arch. of Diag.*, July, 1916).

Study of the relation of ordinary gout to nephritis. Since uric acid is the first of the nitrogenous substances to be retained in interstitial nephritis, while gout and early interstitial nephritis show essentially the same blood-picture, one must employ every possible test to exclude nephritis before a high blood uric acid may be regarded as evidence of gout. Fine (*Jour. A. M. A.*, June 24, 1916).

When all these facts are united, the clinical history, the examination of the joint and of the urine and blood, and the aspect of the Röntgen photogram of the affected parts, the diagnosis will in most cases offer no insuperable difficulty.

ETIOLOGY AND PATHOGENY.—Gout is a markedly hereditary disease affecting men much more frequently than women. As it often occurs in subjects having presented indubitable signs of gravel or uric acid calculi, it seems to be in some way related to that complaint; it has often been observed that, in a family disposed by inheritance to gout, cases of this malady alternate with cases of uric acid gravel or calculi; hence the conclusion was drawn that both diseases had a common origin: the uric acid diathesis.

Developed gout is rarely met with before the thirtieth and fortieth years; it begins rarely after the forty-fifth year, but may in hereditary cases even affect children.

Persons who live freely, eat much meat, indulge in alcoholic drinks, and take little or no exercise are most subject to the disease; but it may also be observed in nervous, lean, underfed subjects, especially when they take much ale or porter and by their employment are exposed to cold and dampness. All sorts of excesses and overwork, bodily or mental, seem to be apt to provoke the attack of gout. Sydenham states that he always had an attack of gout following prolonged mental labor.

There seems to be no question that in some conditions of gout exacerbations, or acute attacks, may be caused by the eating of larger or smaller quantities of proteins containing purin bases (nucleoproteins). This does not show the cause of gout; it shows only that in gouty patients, whatever the digestive or metabolic or excretory cause may be, such products, or such molecules, add to the trouble, and are not well metabolized. There is certainly no justification in declaring that uric acid is the cause of gout. O. T. Osborne (*Monthly Cyclo. and Med. Bull.*, Aug., 1908).

Workmen employed in lead-mills, painters, plumbers, and all persons exposed to absorption of lead are extremely disposed to be attacked by gout (Garrod, Lancereaux, and others).

The disease prevails chiefly in cold and temperate climates, especially when the latter are at the same time damp and changeable; gout may, however, be found also in countries where the climate is warm and equable.

Cantani found it to be not uncommon in Naples, and it is frequently observed among the Arabs of Algiers.

Indulgence in alcoholic drinks and excessive consumption of animal food predisposed to gout; it has therefore been called a disease of the well-to-do classes. Of alcoholic drinks, wines containing a large percentage of alcohol—such as sherry, port, and champagne—have the worst effect; the lighter wines—as claret or Rhine wine—are not so hurtful. Among the malt-liquors ale and porter are reputed to be much more conducive to the development of gout than the lighter kinds of beer; distilled alcoholic beverages—such as gin, brandy, and whisky—are by many authors believed to be less liable to cause the development of gout than beer or strong wine.

Although gout is a malady which has been known to physicians for thousands of years, its pathogeny and real nature are still a subject of debate.

As already stated, the deposition of urates in different structures is the most characteristic feature of gout; the origin of these deposits has consequently been investigated by many observers.

Garrod, in his celebrated work on gout, demonstrated that the blood of gouty patients contains more uric acid than in the normal state.

[This was done by mixing a few cubic centimeters of blood-serum or fluid from a blister with 10 or 12 drops of acetic acid. Threads of cotton were placed in this mixture; this was covered by a watch-glass and left alone for from twenty-four to forty-eight hours. After that space of time the thread was thickly covered with characteristic crystals of uric acid, when the blood was taken

from a gouty patient, especially immediately before an attack. The blood of healthy persons or of patients suffering from diseases not accompanied by uricemia does not give the same results. F. LEVISON.]

The experiments of Garrod have been repeated by other observers, and it is now generally accepted that in gout, uric acid, in the form of urate of soda, is found in the blood in excess. Different questions now arise: How and where in the body is the uric acid formed and what is its physiological significance? Which is the uric acid compound circulating in the blood and excreted in the urine, and how are these deposited to form tophi, etc.? What is the origin of the uricemia in gout, and, if uric acid may also be found in excess in the blood in other diseases, why are deposits of uric acid compounds only formed in gout?

The first question was, until the last few years, generally answered by the statement that uric acid, as well as urea, were products of the metabolism of proteids; the normal result of the complete oxidation of these was urea, only a small amount of proteids being left in a state of lower oxidation and excreted as uric acid. In some persons suffering from a slow and incomplete metabolism—retardation of metabolism—the oxidation of proteids was less perfect, and a larger quantity of uric acid was formed than in health.

Much labor has been spent in calculating the normal proportion of uric acid as to urea in the urine; this has been established by Haig as 1 to 33. According to this author, every departure from this proportion is pathological.

The old theory of the pathogenesis

of gout contended that, when retardation of metabolism took place, much more uric acid than normally was formed; the uric acid accumulated in the blood, and when the blood had thus been loaded with the compounds of uric acid it deposited them in the articulations, etc.

This theory has been overthrown by recent investigations. Kossel, Horbaczewski, and many other investigators have shown that uric acid is not a product of the metabolism of the proteids, but that it is formed by the oxidation of nuclein—an albuminous compound which differs from the proteids in that it contains a greater proportion of phosphorus. The nuclein is contained in the nuclei of cells, and may be prepared from all cellular structures, such as the spleen, the thymus gland, etc.

Various functional tests in 5 gouty patients with tophi as well as in 2 non-gouty patients, showed that in all the gout cases there was definite depression of renal function. A considerable increase in both the non-protein and urea nitrogens in the blood was observed in all but 1 case, and the 2-hour renal test gave clear evidence of disturbed function in 4 cases, with suggestive evidence in another. Many of the findings heretofore considered due to disturbed nuclein metabolism in gout may be explained as results of renal inadequacy, *e.g.*, the faulty elimination of exogenous uric acid and of other nitrogenous substances. The prevailing theories as to the etiology of gout remain hypotheses without satisfactory experimental bases. McClure (*Arch. of Internal Med.*, Nov., 1917).

Schittenhelm, furthermore, has shown the presence of a special tissue oxidase in the kidneys and muscles whose function is to oxidize and destroy the uric acid.

It has further been demonstrated by many experiments that the excretion of uric acid in the urine is increased or diminished by all factors (diseases, medicines, poisons, etc.) which give rise to a more rapid or slower disintegration of the cellular elements of the body and especially of the leucocytes. The ingestion of food causes a temporary leucocytosis (digestive) followed by an increase of the formation and excretion of uric acid. The amount of uric acid excreted in twenty-four hours is not much influenced by the nature of the food (animal or vegetable); there is, however, this distinction noticeable: that the more easily digestible animal proteids set up digestive leucocytosis and formation of uric acid much quicker than the vegetable albumins, which are difficult to digest.

While it is easy to increase the quantity of urea excreted in twenty-four hours by the ingestion of large quantities of proteids, the excretion of uric acid is not much influenced in that way. Weintraub, Umber, and Kühne have demonstrated that the excretion of uric acid may be increased to 2 or 2.5 Gm. in twenty-four hours by giving large quantities of nuclein,—for instance, 500 Gm. of the thymus gland,—whereas the normal excretion of uric acid varies from 0.4 to 1 Gm. per day.

The augmented formation of uric acid will, of course, lead to a temporary uricemia, which usually does not cause any morbid symptoms, but is only characterized by an extraordinary increase of the excretion of uric acid compounds in the urine.

By chemical investigation of the gouty deposits, these have been found to consist of an acid compound

of uric acid with soda, the so-called biurate, and it has commonly been stated that this was also the composition of uric acid circulating with the blood. Roberts has, however, thoroughly investigated this theory and overthrown it.

The researches of Roberts establish that, normally, uric acid exists in the blood as a quadriurate; under special circumstances the quadriurate may be transformed in the blood to a biurate, which gives rise to the deposition of this compound in different parts of the body; the more uric acid is dissolved, the more quickly occur the formation and deposit of biurate, but in all cases the uric acid cannot remain long in solution; if it is not quickly eliminated by the kidneys, transformation of the quadriurate and deposition of biurate are the consequence.

In serum rich in soda salts the biurate crystals are more easily separated than usual; irrespective of the acid with which they are combined, the salts of lime and magnesia, of lithia and piperazin, do not affect the rapidity and the degree of deposition, whereas all salts of potash delay the deposition of crystals of biurate from blood-serum.

The researches of von Jaksch have shown that in various diseases the blood contains an abnormal quantity of uric acid, and different authors have proved this to be the constant result of an increased disintegration of leucocytes. A physiological leucocytosis has been observed in the first days of life, amounting to the double or triple, followed in the fifth day by a sudden fall of the number of leucocytes almost to the normal; this is accompanied by an excessive forma-

tion and excretion of uric acid, giving rise almost constantly to the excretion of uric acid sand and frequently to the formation of uric acid infarctus in the kidneys (Gundobin, Fleusburg). Bartels, Laache, Ebstein, and various other investigators found an extraordinary increase of the daily excretion of uric acid in leukemia; von Jaksch, Laehr, and Ewing observed a hyperproduction of uric acid and leucocytosis in pneumonia, and similar results have been found in the first stage of carcinomatous and all other diseases accompanied by leucocytosis. In all these maladies the hyperproduction of uric acid is distinguished only by the increase of the excretion of this compound, but the existing uricemia is not conducive to gout or any of the symptoms of this complaint. The pathogenesis of gout is consequently not depending on uricemia alone, and it is necessary to examine the special conditions under which uricemia may produce gout.

Various theories have been proposed to explain this. The best supported of them shall now be shortly discussed.

Haig claims that there is "almost never" excessive production of uric acid in the body, but that faulty excretion causes an accumulation. The blood normally is alkaline in reaction and holds a certain quantity of uric acid in solution. If excessively alkaline the blood will hold in solution an abnormal quantity of uric acid. Then some exciting cause, such as cold, acid diet, malt liquors, or acid fermentations in the stomach, results in a sudden acidity of the blood and consequent precipitation of the uric acid into the tissues. This theory of Haig is borne out by the fact that just prior to an attack the blood and urine contain excessive

quantities of acid, while just after the uric acid is precipitated into the tissues the amount of acid in these fluids diminishes for the time. W. C. Schoenijahn (*Med. Rev. of Rev.*, April, 1909).

According to Garrod, gout depends on a temporary or continuous decrease in the ability of the kidneys to excrete uric acid, by which an overcharging of the blood with uric acid is caused. Gout, in his opinion, is never caused by hyperproduction of uric acid, but by retention of it, although the progress of the disease is accelerated by temporary hyperproductions.

Garrod found a distinct diminution of the percentage of uric acid in the urine as well in chronic gout as in the acute cases, except during the attacks, when more uric acid than commonly was excreted; he, therefore, regarded the gouty attack as a salutary process which tends to deliver the system of its surplus of uric acid. It is to be regretted that the analytical methods used by Garrod (Heintze's method and the thread method) are not reliable enough to give full evidence to the correctness of his statements.

The prodromes, the general symptoms, and the nitrogen metabolism of gout show that there is toxicogenic destruction of albumin, as in any acute infectious disease. The presence of uric acid gives the inflammation its specific character. The big toe has the most weight to bear and it is farther from the heart than any other joint, which favors the deposit of urates, while it is particularly exposed to trauma and constant pressure. The urates are deposited where the circulation is most sluggish, and thus prepare the soil for the joint lesion, so that gout affects predominantly the smaller, remote joints, while acute articular

rheumatism settles in the larger joints. T. Silvestri (*Gaz. degli ospedali*, May 31, 1908).

The relations of gout to diseases of the nervous system are, for the most part, indirect. An acute attack of gout may be ushered in or accompanied or succeeded by grave nervous disturbances—even acute manic disorder—but this is not common. Severe neuralgic pains, in parts other than that acutely inflamed, and considerable irritability or depression, may be present during an attack of gout, but no grave structural alteration in the nervous system is to be apprehended as an immediate concomitant or effect of the seizure. Taylor (*Pract.*, July, 1909).

Report of 42 cases of rheumatism and gout in the majority of which pyorrhea had been the direct cause because a cure of the local condition was promptly followed by a subsidence of the constitutional symptoms. Wirgman and Turner (*Lancet*, Dec. 4, 1909).

The observations of the writer in 8 cases of bona-fide gout has led him to believe that the cause is a chronic excessive putrefaction in the intestine of the saccharobutyric form, in which the acute attacks come on from a sudden overloading of the general system with toxins from the intestine, but that this intoxication is always more or less present in the intervals. In these acute attacks the power of the liver to oxidize the purin bases of the body from uric acid into urea is curtailed, and an output of uric acid salts, instead of urea, is the result. We are all aware that urea is a very soluble substance, capable of going into solution in any of the body-fluids, while the uric acid salts, being most insoluble and therefore difficult of elimination, accumulate in the body and become deposited where the circulation is at its lowest ebb, viz.: in the cartilages of the small joints and the fasciæ. Anthony Bassler (*Monthly Cyclo. and Med. Bull.*, March, 1911).

The majority of these joint pains are due to the ingestion of too many tomatoes; there are 288,000,000 cans of tomatoes consumed every year in the United States, to say nothing of the millions of fresh tomatoes. Johnson (*Annals of Surg.*, July, 1912).

The classical attack in the large metatarsophalangeal joint is due to a neuritis in the nerves of the toe, the internal dorsal cutaneous nerve, a branch of the peroneal, and the internal plantar nerve, a branch of the tibial. The reasons are: 1. Pains in the region of the sciatic nerve are frequent in patients suffering from gout. 2. Frequently, immediately after the ingestion of harmful substances, burning and lancinating pains arise in the toe and shooting pains in the sole of the foot along the course of the internal plantar or in the calf of the leg in the region of the peroneus, which disappear as rapidly, without leaving a trace of a swelling or without inaugurating a typical attack. 3. In contrast to articular rheumatism, there exists, in an acute attack of gout, an extraordinary hyperalgesia of the outer integument which is noticeable on very slight contact pressure, even when the least tension on the underlying parts is avoided (Magnus-Lévy). 4. The region of the joint is not tender in all of its parts, but only in definitely localized points, as may be proved by the immediate removal of the hyperalgesia by the application of wet compresses. These points seem to coincide with those places where the nerves traverse the joint. A tender point is constant over the lateral aspect of the foot near the head of the first metatarsal, where a branch of the internal plantar passes. 5. Stretching of the sciatic or peroneal nerve or the pressure of a hard object on them, as in sitting or leaning on the edge of a chair, increases the pain in the big toe or initiates it. 6. The pains of gout become exacerbated in the night, as in sciatica. Adler (*N. Y. Med. Jour.*, from *Med. Klinik*, Nov. 10, 1912).

Although in the light of all the theories on the pathogenesis of gout discussed above and of the observations of innumerable investigators, many questions regarding the real nature of this complaint are still left unanswered, some facts are nevertheless settled beyond all doubt.

It is proved that in various diseases the blood contains an excess of uric acid and that gout is one of these diseases; secondly, it is certain that an excess of uric acid does not cause the deposit of biurate as long as the kidneys are healthy and their action normal.

In all described cases of gout in which the post-mortem examination is mentioned the kidneys have been found diseased, and in almost all cases they were suffering from granular atrophy. Ebstein reported 2 clinical cases of gout in which the kidneys had been found healthy, but close investigation revealed the fact that the cases were so incompletely described as to be utterly valueless in that respect.

In all cases of granular atrophy of the kidneys, the power of elimination of the kidneys as regards uric acid, as well as various other substances, is diminished. Charcot found it defective under the administration of turpentine, which does not give the urine the characteristic odor of violets when the kidneys are granular atrophic. The consequence of this defective elimination of uric acid is its retention in the blood (von Jaksch), and various observers (Ord and Greenfield, Norman-Moore, Levison, Luff) have demonstrated that in granular atrophy of the kidneys deposits of biurate in the joints are very frequently found, even when no

symptom of gout has been manifest during life.

Lead poisoning resembles gout in giving rise to an excess of uric acid in the blood, although it is not accompanied by leucocytes or increased disintegration of whole blood-corpuscles. Now, it appears from experiments on animals (Charcot, Binet, Coen, and d'Ajutolo), as well as from observations of persons exposed to lead poisoning, that one of the earliest and most constant symptoms of this disease is a pathological change of the renal tubuli conducive in rather short time to granular atrophy of the kidneys. This accords very well with the fact that lead poisoning is very liable to give rise to gout, and that Garrod, Lancereaux, and various other observers have found that a large percentage of their gouty patients suffered also from the consequences of lead poisoning.

It has been proved by many experiments that continued irritation of the kidneys by chemical or mechanical irritants leads to inflammatory processes and formation of new connective tissue, resulting in granular atrophy. When the kidneys of patients suffering from gravel and calculi for some time are examined granular atrophy is always found.

When gouty persons are attacked by an intercurrent disease causing a temporary hyperproduction of uric acid,—as, for instance, pneumonia,—they are sure to get an attack of acute gout in connection with it.

When all these facts are combined and confronted they seem without exception to point to a theory of gout closely allied to the views proposed by Garrod.

Gout and its principal symptom—

the deposition of biurates—occur when the blood remains for some time overcharged with uric acid which cannot be eliminated by the kidneys on account of a decrease of their secretory power, which, in turn, is caused (with very few exceptions) by granular atrophy more or less distinctly developed. In all cases of gout the kidneys are diseased, and the gout can never develop as long as the kidneys remain healthy. The morbid state of the kidneys may either be due to inherited predisposition (gout in children, early gout hereditary in families) or be acquired by chronic irritation (lead poisoning, abuse of alcoholic stimulants, uric acid gravel and calculi). As long as the deposition of biurates progresses very slowly no symptom whatever is caused by it, and it is even possible that the deposits may be redissolved without having caused pain or injury at all; but when the deposits grow too large or when from any cause (excesses of every kind, intercurrent diseases, etc.) the production of uric acid gets very large, the deposits increase quickly, the lymphatics are obstructed, and a genuine attack of acute gout is produced. Injudicious therapeutics, such as the abuse of alkaline remedies or springs, are liable to produce attacks of gout by the ingestion of large quantities of sodium salts, which have a distinct deterrent influence on the solution of the quadriurates in the blood.

This theory does not explain all the various and anomalous symptoms of gout, and the question is left unanswered as to why all patients suffering from granular atrophy of the kidneys are not attacked by gout; but it has the advantage that it brings

into one category all the etiological and pathogenic factors with which we are acquainted, and gives a plausible explanation of the origin of gout as well of the rich and overfed classes as of the poor and badly nourished. By this theory the close alliance of uric acid gravel with gout becomes intelligible, and the enigmatic gout caused by lead impregnation has a rational explanation.

PATHOLOGY.—The most characteristic pathological change found in gout is the presence of deposits of sodium biurate in various tissues. The order of invasion is fairly constant: the diarthrosial cartilages are the first to be affected; then the ligaments, tendons, and bursæ; next the connective tissue and the skin become impregnated. Of the articulations the metatarsophalangeal joint of the great toe is generally first affected, then the different metatarso- and metacarpo- phalangeal articulations, the tarsus and carpus, and next the larger joints; but their order is not constant. Almost all joints are attacked by gout,—perhaps with the exception of the hip-joint. The deposit first occurs in the superficial part of the cartilage close under its surface, in the form of fine, crystalline needles forming a more or less close network and presenting different degrees of opacity; sometimes it may be so small as to require the aid of a microscope for its detection. At first the central parts of the cartilages only are impregnated, whereas the peripheral tissues are free from deposits, but present some vascularization. Subsequently the fibro-cartilages, ligaments, and synovial membranes become involved with white chalk-line deposits consisting

of sodium biurate; the synovial fluid may also contain crystal needles. The articulations become stiffened or fixed and ultimately they are greatly distorted and nodulated. The skin covering the affected joint becomes distended, and it may even be destroyed, exposing chalky masses, which break down and are successively evacuated, frequently giving rise to suppurative and ulcerative processes of the skin. It does not mean that the deposit is specially infiltrated in the cells, but rather that it pushes its way without special regard as to the component elements of the cartilage.

Recent research has demonstrated that uric acid can be found in the blood in normal conditions, even on a diet free from purins. The mere discovery of uric acid in the blood on a purin-free diet does not necessarily mean gout. The proportion is much larger in those inclined to gout. This accumulation of uric acid is not due to simple exaggeration of the production of uric acid; when this occurs there is always a larger uric acid output in the urine. In gout the urine does not contain an abnormal proportion of uric acid and it seems as if the endogenous production of uric acid was rather below normal than above. The trouble seems to be retention, and the question is why the abnormally large proportion of uric acid in the blood is not passed out through the kidneys. The kidneys seem to become impermeable for uric acid alone: gout is not uremia.

The assumption seems permissible that either the uric acid itself has become modified in its physical or chemical properties, or else certain metabolic processes which govern the fate of the uric acid have become modified—the trouble does not seem to be in the kidneys themselves. O. Minkowski (Med. Klinik, May 18, 1913).

The periosteum and bursæ may also be implicated, and some authors have even believed that the bone itself may become affected. Virchow has described isolated infiltrations of biurates in the spongy tissue of the phalanges, and in the marrow of the bones deposits may occur, mostly, but not always, in the neighborhood of incrustated cartilages.

Marchand and Lehmann have made chemical analysis of bone-tissue of gouty patients, and found that when the cartilages and the periosteum were removed the osseous tissue itself did not contain uric acid. Garrod observed that in gout of long standing the osseous tissue of the phalanges may become rarefied and the vacuoles filled with fat; by this process the bones are rendered more fragile than in the normal state.

Contrary to what has been observed in healthy subjects, uric acid in gouty patients has a tendency to deposit in the tissues in the forms of crystals of sodium acid urate. These deposits can be found in all the tissues, but predominate in the connective and particularly in the cartilaginous tissues. Brugsch and Schittenhelm (*Zeitsch. f. exper. Pathol. u. Therap.*, Bd. iv, S. 480, und Bd. iv, S. 278, 1909) explain this in the following manner: (1) Cleavage of the nucleoproteids normally takes place until it reaches the stage of purin bases. One finds, for example, in the urine of the gouty to whom 10 Gm. ($2\frac{1}{2}$ drams) of thymonucleinate of soda is injected, that all the nitrogen exists as purin bases, uric acid, and analogous substances reduced to the lowest point of degradation. (2) The transformation of purin bases into uric acid is retarded. In gouty patients a part of the nuclei-

nate of sodium eliminated as purin, without having reached the stage of puric acid. (3) The destruction of the uric acid is lessened, and on this account it accumulates in the blood.

There seems to be no room for doubt that gout can be, and is, transmitted from one generation to another—not, of course, in the acute form, for gouty symptoms are almost unknown before the age of puberty and rarely before maturity is attained—as a well-defined inclination toward the malady after the season of rapid growth and expansion has given place to the period of maturity, quiet, and general prosperity. In general, we can assume that in the normal individual various ferments are actively engaged in breaking down the nuclear substances. Certain of the steps go on with tremendous rapidity. In different individuals the sum total of endogenous purin metabolism will be different, because of individual idiosyncrasies, but in the same person under normal conditions it seems reasonable to suppose a rather constant nuclear metabolism, resulting in the excretion of a fairly constant amount of uric acid in the urine. This accords well with what we know of uric acid in normal urines. Granted, then, this definite mechanism for the metabolism of the cell nuclei and their peculiar proteins, it is apparent that any abnormal change in the relative or total amounts of these enzymes, or a change in the permeability of the renal mechanism, as in nephritis, will be indicated by an abnormality in the amounts of uric acid produced, destroyed, and excreted in a given time. In gout we have undoubtedly such an abnormality of purin metabolism, aspects of which have been made clear by the masterly work of Schittenhelm and Brugsch. Bradley (*Wisc. Med. Jour.*, July, 1908).

Brugsch and Schittenhelm have given uric acid and purin bases to gouty patients with purin-free food and have studied the elimination of

uric acid in the urine and feces. As there was always the possibility of bacterial decomposition in the intestines, the writer (*Zeit. f. exp. Path. u. Therap.*, vii, 339, 1909), at the suggestion of Brugsch, injected a known quantity of uric acid intramuscularly to determine how much of it could be recovered. As the procedure is not without unpleasant consequences, such as marked local and constitutional symptoms, the writer omitted controls on normal individuals, obtaining them from the literature. The work of others has shown that healthy persons excrete 50 to 99 per cent. of uric acid injected intramuscularly. The writer repeated the experiment on a patient suffering with gout. He injected 0.5 Gm. uric acid into the gluteal region; the patient had been on a purin-free diet for several days, and it was found that the average daily output of endogenous uric acid was 0.2101 Gm. During the two days immediately following the injection 81.6 per cent. of that given had been excreted. The experiment shows that the gouty patient eliminated uric acid injected intramuscularly just as a healthy subject does. In other words, the renal excretion of uric acid in the gouty is apparently normal. Benczur (*Amer. Jour. Med. Sci.*, from *Zeit. f. exp. Path. u. Therap.*, Bd. vii, S. 339, 1909).

The writers agree with the conclusions of Brugsch and Schittenhelm in so far as they are concerned with the nuclein metabolism. Yet the elimination of nitrogenous substances of protein origin has a protracted character, and the oxidation of as simple a substance as asparagin proceeds at a subnormal rate. A. Levene and L. Kristeller (*Jour. of Exper. Med.*, Sept., 1912).

Heberden observed a knotty or bosselated condition of the terminal phalangeal joints; this pathological state of the fingers has been known as Heberden's finger. In Heberden's

opinion, the knots are not of gouty origin, but caused by arthritis deformans; a similar formation of the phalanges may, however, also be observed in gouty patients in very advanced life.

Deposits may be found in various other parts of the body, such as the external ear, eyelid, nose, and larynx; they form there nodules—tophi—which at first contain a liquid, but after some time get hard. Garrod evacuated from a single tophus of the hand 60 Gm. (2 ounces) of sodium biurate.

The muscles of gouty patients are ordinarily atrophic, especially when the extremities get stiffened and immovable.

The heart is frequently hypertrophic; myocarditis may occur, leading to the formation of fibroid or fatty degeneration of the muscles. The endocardium is sometimes in a state of chronic inflammation, and uratic deposits have been observed in it. In the aorta arteriosclerotic changes and uratic deposits have been noticed.

In diet free from purins the serum of normal man may still show uric acid in quantities large enough for measurement, while if the subject be typically gouty the uric acid in the serum may not equal the normal values. Hence in a typical gout, so called, a little uric acid in the blood has no diagnostic significance. The concentration of H ions in the blood of the gouty is often considerably greater than that of the normal blood, and also of diabetics with coma and precoma. Hence the alkalinity of the blood may be decreased in gout. The blood-serum of the gouty occasionally has a slight lipid look. Ehrmann and Wolff (*Münch. med. Woch.*, Sept. 23, 1913).

In the digestive tract congestion and a catarrhal stage are found, as

well as ulceration of the mucous membrane; but as the ulcerations are observed only when the granular atrophy of the kidneys is fairly developed, they are probably caused by the renal disease and cannot be regarded as directly gouty.

Gout of the intestines is essentially a catarrhal process which affects primarily the mucous lining of the entire alimentary canal, and may be limited to it or involve the neighboring fibrous tissues. It follows the usual course of catarrhal inflammation, beginning with congestion and marked by mucous, mucopurulent, or purulent exudation, being more amenable to treatment in the early stages. If unchecked it produces ulceration, increase of connective tissue, adhesions, and distortion of structure, more rarely to definite and visible deposit of biurates in bulk, and not uncommonly to an interstitial accumulation. Parts exposed to cold, acids, heat, or irritant substances are first affected, and it may spread by fibrous tissue continuity or by microbic invasion along with urate precipitation and impaired circulation and metabolism. The chronic irritation produced in the tissues paves the way for cancer, which affects chiefly the parts exposed to cold, acids, heat, and irritants. The warmer parts having a large supply of alkaline blood or secretions are avoided by catarrh and cancer alike, while the acid parts, stomach and rectum, are favorite seats. The relation of these intestinal troubles to gout and rheumatism is constant, and like bronchial and other respiratory catarrhs they are all made worse by acids, cold, and retentives, and better by alkalis, heat, and uric acid solvents, thus aiding diagnosis. Haig (*Med. Rec.*, Oct. 12, 1912).

The liver is commonly enlarged and in a state of fatty infiltration or of interstitial hepatitis; when this is the case, the spleen may also be enlarged.

The kidneys are always more or less pathological. In the large majority of cases they are granular-atrophic: the kidney is contracted with a rough and granulated surface, small cysts are commonly seen on it, the capsule is adherent in different places, the color of the organ is red, the cortical substance warty and granular, and the walls of the arteries generally thickened; in short, the gouty kidney is identical with the small, granular kidney. In some cases deposits of biurate are found in the tubuli or between them, appearing as whitish points or lines in the red structure of the organ. Uratic deposits may also be found in the pelvis and in the bladder.

A few observers have noticed the presence of sodium urate deposits in the meninges of the brain and in the neurilemma of peripheral nerves.

PROGNOSIS.—Acute gout is rarely immediately fatal; the attacks are very liable to return, but much depends on the mode of living adopted by the patients. Chronic gout decidedly shortens the life of the patients and often results in crippling them completely. The kidneys are always diseased in gout, and, when the granular atrophy of the kidneys develops to its utmost, there may be serious danger from the retention of the constituents of the urine, and gouty patients may die from uremia.

Gout diminishes the power of resistance against acute disease and injuries; many gouty patients, nevertheless, reach an advanced age.

TREATMENT.—Prophylactic treatment of gout is of the greatest importance not only to prevent the first attack in the case of hereditary

disposition, but also after the first attack to prevent or at least delay recurrences.

Dietetic Treatment.—Gouty patients should avoid all aliments containing nucleoproteids, which, necessarily, tend to increase the percentage of uric acid in the blood; hence are contraindicated all glands and internal organs composed chiefly of cells, such as brain, kidney, sweetbreads, liver, and especially thymus gland; also meat-extracts contain much nuclein and are not to be allowed. Eggs do not contain nuclein, but paranuclein, which in the body is not decomposed into uric acid, and moderate quantities of eggs, therefore, can be eaten by the patients.

The first point of attack in the rational treatment of gout is the uric acid circulating in the blood, *i.e.*, the uricemia. Just as it is necessary in diabetes to keep the patient on a non-sugar-yielding diet for several months or even years, it is necessary to prevent a gouty patient from eating purin-yielding food. By prolonged care in the diet most cases of uricemia not complicated by diseased kidneys can be cured. Some of the uric acid in the blood comes from the breaking down, within the body, of white blood-cells and other nuclein-containing tissues, but the purin-free diet must reduce the uric acid salts in the blood. Meats and flesh of all kinds, even fish, contain purin bases and to prevent uric acid from being formed from the diet, flesh of all kinds must be prohibited. It has long been known that foods that are rich in purins, such as liver, pancreas, thymus, brain, or other sweetbread tidbits, shad roe or of other fish, should be excluded from the diet of a gouty patient. Alcohol in any form taken with an ordinary meat meal increases, probably by its action on the liver, the formation of uric acid. Consequently, alcohol in

any form should not be allowed to patients with a meal which contains meat, even if alcohol is allowed between meals, or with other foods. Schittenhelm (*Therap. Monats.*, Bd. xxiv, Nu. 3, S. 113, 1910).

Boiled meat contains less purin bodies than roast, but fish does not differ materially from meat in general in this respect. Small fish contain more purins than beef and pork. O. Minkowski (*Med. Klinik*, May 18, 1913).

On a number of occasions the writer has been promptly relieved, without medication, by a **rice diet** for a number of days, and has also used it successfully in other cases.

The diet consists of rice, butter, bread and water exclusively, 3 times daily for from 5 to 7 days. The rice should be eaten hot, with butter and not with sugar and milk, for half an hour or more at each meal, with thorough mastication. He gives $\frac{1}{2}$ pint of water, not iced, with each meal, but not when food is in the mouth, and also $\frac{1}{2}$ pint of hot water, an hour before the morning and evening meal. Bulkley (*N. Y. State Jour. of Med.*; *Amer. Med.*, Apr., 1917).

As the proteids do not change into uric acid, there is no reason to prohibit meat or fish in moderate quantity; about 200 Gm. ($6\frac{1}{2}$ ounces) daily is quite sufficient, and a larger quantity will only tax the digestion and the secretory power of the kidneys.

All sorts of farinaceous aliments, bread, milk, cheese, fruits (when they do not disagree), and vegetables of every kind, are to be allowed.

Chemical study of the metabolism of 137 cases of gout. The elimination of uric acid, according to the writer, follows typical curves. The amount of endogenous uric acid grows less and less until the onset of an acute attack of gout, when there is a rise in the curve. This rise attains its maximum height two

or three days after the onset of the acute attack. Then there is a gradual falling off in the uric acid elimination to amounts below the normal during the intervals between the attacks. These curves of uric acid excretion are typical of gout. In view of the researches of Brugsch and Schittenhelm, it is to be expected that the excretion of the exogenous uric acid following the ingestion of purin-rich foods would be much less prompt than in normal subjects. This is found to be the case. The writer concludes from these studies that there is no medicinal treatment of gout other than measures directed to relieve the symptoms at the time of the acute attacks. In the intervals therapeutic effort must be directed entirely to a consideration of the diet. The gouty person should never take more than 200 Gm. (6½ ounces) of meat a day, and when an attack is impending no meat should be allowed. It is still further advisable to arrange several purin fast days in each week, and thus give the body the opportunity to eliminate its excess of uric acid. This regimen must be kept up for months and years in order to avoid the later severe stages of this disorder. **Drinking large amounts of water** aids in the excretion of uric acid, but, contrary to the long-accepted opinions, alkaline waters have the opposite effect. None of the alkaline or mineral waters has any specific effect upon gout, and this is especially true of the lithia waters. Umber (Therap. d. Gegenwart., Bd. ii, S. 73, 1909).

The writer makes the following axiomatic statements: Experience shows that gout can in most cases be favorably influenced by diet. Food poor in purin is rational and may be tried if it proves agreeable to the digestive organs. There is no reason why this diet should be persisted in, if there is no distinct effect after a few weeks or months. In that case a simple but varied food with plenty of vegetables and fruit is indicated, digestion permitting. Special dietary

directions are required where moderation is not vouchsafed by the intelligence and character of the patient. There should always be moderation in the use of alcoholic beverages, while total abstinence is necessary only in isolated cases. The kind of beverage permitted depends upon the susceptibility of the patient and on the customs of the country. His (Zeit. f. arzt. Fortbildung, Oct. 15, 1909).

The food should be adequate in amount; the main classes of food-stuffs should all be represented; there should be preferably some restrictions of the proteins; the food should be well, but plainly, cooked and digestible. Twice-cooked, rich, and highly seasoned foods should be excluded. Foods rich in purins should be forbidden, and wines and beers avoided. Lastly, the dietary should be adapted to the individual needs of each patient, taking into account any complicating factors. If these main requirements are fulfilled, the regulation of the details may be left in the hands of the individual prescriber. A. E. Garrod (Lancet, June 28, 1913).

There is no rule applicable to all gouty persons with reference to their allowance of meat. In general, meat in moderation is in no way harmful, but beneficial. Strong meat soups and beef extracts are to be avoided; pickled or salt meats are, as a rule, inadvisable, but they need not be absolutely excluded from the diet. Meat should be roasted or broiled; mutton is better than beef and much better than poultry for the average case. Liver, sweetbreads, and kidneys should not be allowed. A purin-free diet works very well in many cases of gout. However, there are patients who cannot bear this diet long. Fish and some shellfish, if eaten fresh, are harmless. The writer allows ordinary bread, plain or toasted, or plain biscuits. He believes that plainly cooked potatoes are entirely harmless. Green vegetables, especially spinach, cress, and lettuce, are of value. Asparagus

should be given very sparingly. Fruits, both cooked and raw, may be given to gouty patients. Tea, coffee, and cocoa have no bad effects, with the exception of strong black coffee taken after meals, which he prohibits. A single wine in small quantity, preferably port, Bordeaux, or champagne, is allowed. The writer deprecates large mixed meals of animal and farinaceous food elaborately prepared and richly seasoned. He forbids cooked tomatoes, rhubarb, and food cooked with fat or sugar. Sauces, relishes, and highly spiced food must be avoided. Both lemon juice and vinegar are harmful. Mustard and salt may be taken in moderation. **Abundant water** should be given to gouty patients, and should contain little calcium or iron. The continued use of alkaline or lithia drinks often is harmful and should be forbidden. Duckworth (Pract., Jan., 1909).

Fats are to be allowed in quantities that will not produce acidosis. The amount of food, moreover, should not be excessive, and regular movements of the bowels must be insisted on (salines).

It is useful to prescribe rather large quantities of inoffensive beverages, such as pure water and milk, especially skimmed milk or butter-milk, to favor the free action of the kidneys. Tea and coffee are allowed, in moderate amounts, and also light, dry cider.

Eight cases of gout in which the beneficial effect of **cider**, when substituted for wine as an exclusive beverage, was clearly shown. The acute attacks either ceased entirely or became much less frequent, even, in 3 instances, where tophi were already present. Where wine (Bordeaux or Burgundy) was resumed, and cider discontinued, an attack soon took place. In several patients in whom restriction to mineral waters had yielded but slight benefit, cider

proved far more efficacious. Motais (Bull. de l'Acad. de Méd., July 2, 1912).

The quantity of urine per twenty-four hours ought to be about 1500 to 2000 Gm. (3 to 4 pints). Alkaline springs have been much recommended, but not on very solid grounds. Their use should not be exaggerated, as the ingestion of much soda in the blood is liable to accelerate the deposition of biurate, and thus provoke an attack of gout.

Open-air exercise is very useful in the treatment of gout, and, when possible, gouty patients ought to spend their holidays in regular active exercise, such as walking, cycling, riding, etc.

Treatment of Hereditary Gout.—

Much can be done in these cases by the use of proper dietetic and hygienic measures. The children of gouty parents should be taught early the relation between food and **exercise**. They should go hand in hand; any increase in food demands additional exercise, and when exercise is not available the diet should be low. Proper clothing should be provided to protect from the effects of changes in temperature, and draughts should be avoided. Malt liquors and sweet wines should be interdicted, and milk and eggs should be used rather than meats and pastry.

With respect to those persons who are goutily disposed by inheritance in any degree, the treatment may be said to consist mainly of an appropriate nutrition with some restriction of animal food and a limited amount of saccharine matters, especially of food cooked with sugar and fatty materials. Meals consisting of animal food and carbohydrates, with sugar, taken at one time, are found to be imperfectly digested by such

persons. An **open-air** life, especially in inland and somewhat elevated districts, is desirable. Water much impregnated with lime is improper. Marine districts, especially in exposed situations, are apt to be unfavorable for most of these subjects. Occasional **aperients**, containing some mercurial, are of especial value. In cases of an asthenic type, especially in young girls with feeble circulation and tendency to chilblains, it may be desirable to employ a small quantity of some **red wine**,—Bordeaux or Burgundy,—well diluted with water, with the principal meal of the day. Exposure to cold and damp is especially to be avoided. Maylard (Lancet, May 6, 1911).

Treatment of the Acute Attack.—

Abortive treatment of an acute attack of gout has repeatedly been tried, but it is not to be recommended, being attended with the great risk of inducing an attack of internal gout. The method proposed has been strapping the affected joint with adhesive plaster; the application of snow or ice; the hypodermic injection of morphine; large doses of colchicum, etc. Undoubtedly the attack may be stopped short by these methods, but very dangerous symptoms, such as fainting, disorder of the action of the heart, etc., have been observed as the immediate result of these procedures.

Although medicine has now abandoned the old maxim that during the attack the affected joint was only to be treated "with flannel and patience," the treatment of the attack ought not to be too active. The patient should remain in a recumbent position, though not necessarily in bed, for some days; the affected limb should be raised and supported, kept warm, and protected from pressure. The pain is relieved by **warm alcoholic lotions**, application of **opium oint-**

ments, **liniments**, or **menthol** in an alcoholic solution. **Ointments of ichthyol** are also to be recommended.

Most of the remedies are useful, mainly through the suggestion of relief they afford to sufferers. Blood-letting and blisters were formerly in use, but are now generally abandoned, as they have a tendency to give rise to internal gout.

English practitioners often begin the treatment of an attack of gout by the administration of a free purgative: **calomel** and **jalap** or **mistura sennæ composita**.

Of remedies directed toward the gouty process itself **colchicum** is the most effective; its mode of action has been solved by modern study and investigation. Rutherford has demonstrated its great cholagogue powers, and, as the liver has largely to do with uric acid formation, the mode of its action is apparent, and also why it produces its sedative and anesthetic effect without necessarily causing purgation or vomiting; in fact, these latter effects are to be avoided, and, if purgation is thought desirable, it is better to add some aperient to the colchicum. But it seems to relieve the pain better than any drug; colchicum is ordinarily prescribed as wine of colchicum and may well be combined with tincture of **aconite**; 25 minims (1.5 c.c.) of wine of colchicum with 3 to 5 minims (0.18 to 0.3 c.c.) of tincture of aconite may be given three or four times daily. The use of colchicum ought only to be continued from four to six days, as it is liable to produce nausea and diarrhea, and even paralysis of the nervous centers when taken too long a time. An alkaloid of colchicum—**colchicine**—is employed in doses of $\frac{1}{120}$ to $\frac{1}{30}$

grain (0.0005 to 0.002 Gm.) two or three times daily. The salicylated colchicine of Merck, a yellow powder, may be given in the dose of $\frac{1}{80}$ grain (0.0008 Gm.) four times daily. As soon as the anodyne effect of colchicum has been reached the use of the drug is to be discontinued. Under any circumstances, however, it should no longer be given when nausea or diarrhea sets in.

Tyson considers the **salicylate of sodium** as much superior to colchicum, although not so rapid in its effect. He advises 15 grains (1 Gm.) to be given four times a day, or 10 grains (0.65 Gm.) every two hours. Even larger doses may be given if well borne by the stomach. When the symptoms improve, the dose is lessened, but its use, however, must be continued for some time. The **salicylate of lithium** has also been recommended.

It is difficult to enforce a very rigid régime on a gouty subject; he should, however, eat only 1 part of animal food to 3 parts of vegetable. He should be moderate as to sleep and take no after-dinner siesta. As to meat, beef, mutton, and fowl, not the meat of young animals. Of the vegetables, oatmeal, beans, peas, mushrooms, asparagus are taboo. Sugar, butter, fats, bread may be taken in moderation. Spiced foods should be avoided. Only 2 eggs daily are permissible. **Sodium arsenate** is sometimes useful, and should be taken for four days at a time, followed by four days' suspension, for a month. After this month the following may be tried:—

Rx Sodium phosphate,
Sodium benzoate,
of each gr. cl (10 Gm.).
Distilled water ... ℥x (300 c.c.).

M. et ft. mist. Sig.: Tablespoonful before breakfast and dinner.

This prescription should be used for ten days. Then medication should cease and **mineral waters** be taken for a month.

In chronic gout more meat may be taken; **sodium salicylate** or **phosphate** may be given. Tophi may be treated by the **thermocautery** or **galvanocautery**. **Massage** is useful in helping general nutrition, stimulating intestinal peristalsis, and combating muscular atrophy. **Vichy** is recommended for the florid overeaters, **Royat** for the weak, **Contrexéville** for those with arterial supertension. The **chalybeate waters** sometimes cause painful attacks in the anemic, gouty patients, but act well, if cautiously given, in certain dyspepsias and rundown conditions. Robin (*Bull. gén. de thérap.*, March 23 and 30, 1911).

When the pain has subsided and the swelling of the joint is somewhat diminished, gentle use of the joint and careful (but not energetic) **massage** are useful.

In the interval between the attacks the tendency to renewed attacks by the prolonged use of **alkalines** is of importance. Of these the **carbonates** and the **phosphates of sodium** and **potassium** and the **carbonate of lithium** have been most employed, but their use is now known to be based upon fallacious deductions.

Tyson states that after the salicylates the alkaline carbonates have always held a high position. He gives $\frac{1}{2}$ ounce (15 Gm.) of **potassium bicarbonate** a day, in divided doses as the initial treatment, continued in smaller doses when the acute symptoms are relieved. A little lemon-juice improves the flavor. The **citrate of potassium** may be given in the same dose. **Lithia** is not so useful in acute gout as in the chronic form, in which it may be given in

doses of 5 grains (0.3 Gm.), dissolved in a large glass of water, four times a day.

The writer believes that the late Sir William Roberts's simple prescription of $\frac{1}{2}$ dram (2 Gm.) of **bicarbonate of potash** in a tumbler of water at bedtime, to stem the nightly acid tide, is, on the whole, one of the most useful recommendations, apart from **tonics**, **cures at watering places**, and **change of scene and air**. J. F. Goodhart (Pract., July, 1909).

Abstinence from sodium is an important therapeutic measure. **Potassium**, on the other hand, counteracts the injurious influence of the sodium and should be given systematically. The writer has taken the potassium salts himself and given them to patients for weeks and months at a time and never witnessed any injurious by-effects, while they displayed a marked influence in attenuating the gouty process. Cohn (Berl. klin. Woch., March 18, 1912).

Good reports of the effects of **atophan** (phenyl-quinolin-carboxylic acid) in gout are made by Bach and Strauss, Retzlaff, Weintraud, Deutsch, Kahlo, Georgiewsky, and others.

The writer, as a result of the careful observation and close study of a large number of gouty cases, reaches the conclusion that **atophan** is the best drug we at present have in acute attacks of gout. He uses it in dosage from 40 to 60 grains (2.6 to 4 Gm.), and states that as a rule there are no undesirable side actions except occasional digestive disturbances. Small amounts of **soda** given at the same time with atophan usually prevent these symptoms. In chronic gout the results are not so satisfactory. Deutsch (Münch. med. Woch., Dec. 12, 1911).

In 19 cases of gout treated with **atophan** in doses of 0.5 Gm. ($7\frac{1}{2}$ grains) combined with **sodium bicarbonate**, 5 Gm. ($1\frac{1}{4}$ drams), at four-

hour intervals for three-day periods, the periods of treatment were followed in every instance by an increased uric acid excretion to double that existing before the treatment. Usually the increase in the uric acid was noted on the first day of the administration of atophan. The withdrawal of the remedy was followed by a decline of the uric acid excretion below the normal that slowly rose to its former level. The administration of the remedy gave rise to no kidney irritation and no increase in the amount of the urine. Bach and Strauss (Münch. med. Woch., Bd. lix, S. 1714, 1912).

The writer used **atophan** in 48 cases—acute, neuritic, and chronic—with greater relief than had been obtained from other remedies, except in the chronic cases, in which effects were slight. Gouty sore throat and coryza also generally benefited. Dose, 30 to 60 grains (2 to 4 Gm.) a day, in $7\frac{1}{2}$ -grain (0.5 Gm.) tablets, 1 or, in severe cases, 2 after each meal and at bedtime, or every two or three hours. Kahlo (Therap. Gaz., Dec., 1912).

Quite recently Schmidt, of Frankfurt, has advocated the use of **hydrochloric acid** in continued high doses, in cases of gout with hypochlorhydria. Falkenstein also recommends its use.

Result of five years' application of the writer's **hydrochloric acid** therapy in gout. The method consists of the continuous administration of considerable quantities of concentrated pure hydrochloric acid, which is given well diluted after meals. The author himself has taken during more than five years, without any interruption, 50 to 60 drops daily of the concentrated acid without any untoward effects, and with very great relief to his gouty symptoms. He has treated 390 cases of the disease. The patients are divided into three groups: 1. Patients who have had the disease for only a few years and who, accordingly, have only moderate

uratic deposits. With these the hydrochloric acid treatment is usually very effective and a permanent cure is possible. 2. This class includes cases of chronic typical or irregular gout in which, in the course of years, very considerable deposits and tophi have formed. These patients also experience great improvement in the general condition and cessation in the progress of the disease. Further attacks are not altogether prevented, but are usually not severe. The acid is effective only in preventing new deposits and does not cause solution of those already present. 3. This includes the severest cases of chronic gout, and patients of this type apparently benefit but little by the use of the acid. Falkenstein (Berl. klin. Woch., Dec. 2, 1907).

Various basic organic products—piperazin, lycetol, lysidin—were at one time recommended as specifics for uric acid gravel and gout on account of their power to dissolve uric acid. Mendelsohn has tried the effects of all these compounds, and found that urine saturated with them does not dissolve uric acid any more than normal urine, and they are, of course, still more ineffective when circulating in feeble concentration with the blood.

Uricedin, a remedy proposed by Mendelsohn, is a combination of citrate of sodium, sulphate of sodium, and small quantities of common salt and citrate of lithium. It may be of use in the treatment of uric acid gravel, but in gout it is about on a level with the other compounds of soda.

The writer has obtained good results by the use of **thyminic acid** in the treatment of gout. It hastens the elimination of uric acid. Thyminic acid, as well as uric acid, is produced by the oxidation of the purin bodies. It forms a combination with

uric acid which is soluble and which cannot be precipitated. Thyminic acid is now prepared synthetically, and the writer advocates the daily use of 4 grains (0.26 Gm.), taken after meals for a period of three months and then every alternate week, to prevent the onset of acute symptoms. It is especially suitable for the prevention of acute exacerbations of chronic gout and for the gradual improvement of the symptoms of a chronic or irregular gout. For the acute attack, thyminic acid is not invariably successful and he prefers to use in such cases **mercurials** with **colchicum** or colchicum with **aspirin**. After the acute attack has subsided large doses of thyminic acid should be given, together with appropriate local treatment. Fenner (Lancet, vol. ii, p. 1804, 1908).

Bier's stasis treatment is useful in the acute stage, in view of the fact that blood-serum is the best solvent of uric acid. The hyperemia should be associated with alternately hot and cold applications locally, the constricting band being removed at the end of two or three hours. Thereafter the writer keeps the limb elevated, applying **cold compresses** for two hours, and then **hot fomentations**. This treatment quickly puts an end to the attack. Alkan (Pract., Aug., 1907).

Lithia salts not only do not dissolve uratic concretions, but they upset the stomach very easily. In the gouty it is indispensable to keep the digestive functions at their best. Piperazin in no way promotes the elimination of uric acid, as Fannel and Luff have proved. Salicylate of soda in large doses, recommended by Fannel, thoroughly upsets the stomach, and, according to Luff, has not the least effect in dissolving gouty deposits. Lysidin is in no better repute. A possible exception, perhaps, is to be met with in **thyminic acid**—a product of the decomposition of the nucleins. When this is present it combines with uric acid and insures its solution, but when absent precipi-

tation of uric acid occurs. Schmoll estimates that thymine acid brings about an increase in the gouty of the elimination of uric acid by the urine, which may reach to 25 or even 50 per cent. higher than the normal amount. It is given in cachets in doses of 4 grains (0.26 Gm.) before meals. Robin prefers **quinoformine**. The practitioner may try these two remedies alternately for periods of ten days.

When the joints remain enlarged and puffy, **massage** will be of great benefit, provided all pain has gone. The **Scotch douche** succeeds in chronic cases. Baths of **superheated air** are equally useful. When a joint is disabled by large gouty deposits, **cataphoresis** has brought about good results. The joint is placed in a bath of **iodide of lithia** (2 per cent.), or of 5 per cent. **bicarbonate of potash**. The positive electrode is placed in the bath; the negative pole, moistened with hot water, is applied to the lumbar region. A current of from 150 to 200 milliampères is passed for from twenty to thirty minutes. The lithia is said to penetrate the tissues, and being brought directly into contact with the gouty deposit tends partly to dissolve it. Editorial (*Journal des praticiens*; Pract., July, 1909).

Mineral Springs.—A considerable number of springs to which gouty patients commonly resort are strongly impregnated with the salts of soda; it is not, therefore, surprising that not infrequently the first result of the cure is to provoke an acute attack of gout or to aggravate the symptoms with which the patient was suffering. The physicians practising at these resorts are accustomed to consider this aggravation as of good augury. Perhaps they are right, as it does happen that a patient who for some time has been laboring under the preliminary symptoms of gout feels better when the attack has

passed over and a large quantity of uric acid has been removed from the blood; but it is a rough mode of cure, and many physicians, especially the English, now advise the patients to avoid strong alkaline springs or to use their waters sparingly. Roberts resumes his opinion of the strong alkaline springs (Vichy, Carlsbad, etc.) in the treatment of gout in the following words: "It is difficult to believe that they can do any direct good, and easy to believe that they can do direct harm."

In cases of gout in which the urine constantly precipitates crystals of uric acid, it is advisable to prescribe some alkaline remedy or alkaline spring-water, to prevent the precipitation and the irritation of the kidneys caused by it; the doses should, however, be regulated by the degree of acidity of the urine, and not more of the alkaline drug is to be taken than necessary to reduce the acidity of the urine to the normal level and thus render it limpid and without deposit of crystals.

Some springs are devoid of the dangers dependent on the use of the strong alkaline waters, as they do not contain the salts of soda or only very small quantities of them; they are either aerated, contain but little besides the pure, warm water, or they contain some carbonate of lime or sulphate of lime; in many cases the free use of these springs, combined with douches, moor baths, massage, and hydrotherapeutics in its different applications, will be useful, especially against the stiffness of the joints remaining after acute attacks.

Among the most renowned springs of this kind may be mentioned **Buxton** and **Bath**, in England; **Aix-les-bains**

and **Contrexéville**, in France; **Wildbad**, **Gastein**, and **Pfeffers**, in Germany and Switzerland, and **Sandifjord**, in Norway.

Medicinal and Other Measures.—Of the drugs which have been recommended against gout, **guaiac** merits special mention. It was introduced by Garrod, and is administered in a dose of 7 to 10 grains (0.45 to 0.65 Gm.) of the resin daily, ordinarily combined with **iodide of potassium** or **quinine**. It seems to have a very good effect in many cases, as it is well supported by the patients, even under protracted use. It seems to retard the return of the gouty attacks.

The treatment of gout by **radium** emanations is advocated by His, Gudzent, Bechhold, Ziegler, and others; but the method is still on trial.

Results with the **radium** treatment of 100 cases of chronic rheumatism and 28 cases of gout. Forty-seven were improved, 29 considerably improved, 5 cured, 13 were uninfluenced by the treatment, and in 6 no result was apparent. The writer adds that the majority were severe cases that did not respond to other methods of treatment. He gives the details of some of these cases. The best results occurred in the early stages of the disease. Of the 28 cases of gout only 4 were unimproved, while 24 were markedly improved, some completely cured. The writer does not believe that radium is specific in gout, but that it is most useful in certain cases. No result is to be expected in patients with bony ankylosis. His (Berl. klin. Woch., Bd. xlviii, S. 197, 1911).

Radium emanations were used in 400 cases of gout and chronic arthritis by the writer. He places the patient in a closed radium room for 24 to 36 sittings of two hours each. Injections of soluble radium salts near involved joints were given in addition; also **superheated air**, **elec-**

tric light, and **brine baths**. Absolute rest in bed is important. Out of 50 cases in which blood was examined before and after treatment, uric acid disappeared in 37 instances, synchronously with marked amelioration. Children were particularly benefited, but cases of senile tuberculous and syphilitic arthritis and cases of very long standing, with marked joint changes, are not suited for radium treatment. Gudzent (Berl. klin. Woch., Nov. 20, 1911).

The writer has seen none of the favorable results ascribed to radium by others. It may expel the uric acid from the blood, but without thereby influencing the severity of subsequent attacks. Still, the method is in its infancy as yet and he does not discourage its use. Inhalation is the proper method of exhibition. Large doses of **hydrochloric acid**, once thought to be eminently contraindicated, are known to prevent the formation of uratic deposits, and may be given when there is no evidence of hyperacidity. Richter (Deut. med. Woch., Dec. 21 and 28, 1911, and Jan. 4, 1912).

Edison, and after him Labatut, Levison, Chauvet, and Gilles, have advocated the **electric treatment** against the stiffness of gouty joints; by this treatment remedies are introduced through the skin by the aid of a **galvanic current**. The experiments of Labatut and other scientists have demonstrated that the alkaline substances enter into the body with the positive current, whereas the acids are introduced with the negative. The remedy employed in this way against the gouty affections is **lithia**, which is liberated by the decomposition of the salts of lithia by the electrolytic effect of the current and enters through the skin in the nascent state, and consequently in a very effective condition. Labatut conducts the dielectric treatment in the fol-

lowing way: A 2 per cent. solution of **chloride of lithia** is rendered alkaline by addition of some caustic lithia or carbonate of lithia, and the hand or foot which is to be treated is placed in a saucer filled with the solution, into which also the positive conductor is plunged, taking care that the conductor does not touch the skin; the negative conductor (both conductors are made of charcoal) is placed in another saucer filled with a feeble solution of common salt, and some part of the body, hand or foot, is put into contact with this liquid. A current of 15, 20, or 25 milliampères is used, according to circumstances, and each *séance* is of thirty minutes' duration. By the continued use of this method, I have in many instances succeeded in restoring to gouty joints the mobility which had been lost for several years. While it is also possible to dissolve tophi, some part of the swelling caused by the deposits will, however, always remain, as the tophi do not consist only of biurate of soda, but contain also new-formed connective tissue, which cannot be dissolved by the lithia.

Cataphoresis is useful in many cases of chronic gout with considerable deposits in the joints. The joint may be treated either by immersion in a local bath of the fluid which is to be introduced, the positive electrode being placed in the bath and the negative on the back, or the positive electrode may be kept thoroughly wet by frequent applications of the fluid. The negative electrode should be a large one, about 8 by 5 inches, made of zinc and protected by a flannel cover. It is well moistened with warm water, and applied to the lumbar or dorsal region. At the positive pole either **potassium bicarbonate** or **lithium iodide** may be introduced into the

affected joint. In the former instance the positive electrode is kept thoroughly wet with a saturated solution of potassium bicarbonate; in the latter the joint is painted over with iodide liniment, and a pad of lint soaked in a saturated solution of lithium carbonate is laid over the iodine surface; on the lint the positive electrode, which should be a large, flat one, is placed, and closely applied to it. Care must be taken to have everything *in situ* before turning on the current, so as to avoid any shock, and to give an easy, steady flow of current. Luff (*Pract.*, July, 1909).

Since Burian and Schur drew attention to the muscles in gout these tissues have come in for investigation at the hands of several writers. Burian found that hypoxanthine was normally produced in muscle, and as soon as made was oxidized to uric acid. The uric acid was then partly destroyed in the liver and partly excreted by the kidneys. He also noted that during activity of the muscles a certain amount of the purin base escaped oxidation, and so there was relatively a larger amount of purin base as compared with uric acid thrown into the circulation.

Kennaway, in an article on the effect of muscular work on the excretion of endogenous purins, found that during unaccustomed exercise the uric acid output of the kidneys diminishes, while that of the purin bases is relatively increased, but on the whole he ascertained that the total purin output (bases plus uric acid) was not very much increased. After exercise the processes by which uric acid is produced are heightened. Salicylic acid caused greater excretion of uric acid in the urine without giving rise to any increase in its formation. **Salicylic acid** and **exercise** act quite independently of one another, and when used together the amount of purin bodies excreted is extremely large. His work tends to show that during exercise the increase of the purin bases and the

relative decrease of uric acid may mean that there is deficient oxidation of the former. He did not, however, find that the giving of oxygen had any notable effect. A. W. Sikes (Pract., July, 1909).

For a period of 15 years the writer has given to patients in an acute attack of gout, involving the smaller joints or the knee, treatment which consists of applying sponge electrode saturated with the fluidextract **colchicum** (Squibb), attached to a galvanic, reversing the current every 2 minutes, using the current of strength up to the patient's point of tolerance of pain. Three treatments in 36 hours would relieve all the acute symptoms of pain, swelling, etc. H. W. Frauenthal (Journal of Advanced Therapeutics, June, 1913).

Arsonvalization gave the writer constant success in 14 cases of muscular gout with distressing infiltration in muscles, tendons and subcutaneous fat tissue. Massage and baths are only palliative and are painful, but under the electricity the relief was prompt and the infiltrations disappeared. The benefit was permanent even in cases of 23 years' standing. The sittings were for from 15 to 45 minutes; from 20 to 28 sittings were required to free the patient completely from his symptoms. Andersen (Ugeskrift for Laeger, Apr. 14, 1921).

Another new and valuable addition to the therapeutics of gout is the **hot-air bath**. In all the different forms of baths, mineral bath, moor baths, Turkish and Russian baths, which have been employed for a long time with varying success against gout, the heat is the common active principle. It is difficult to bear more than 50° or at most 60° Celsius when the heat is applied as vapor bath, moist air, or hot water; but when the heat is administered by means of dry air, a far higher temperature is borne without pain or damage.

Tallermann, of Sheffield, and Betz, of Chicago, have invented ingenious apparatuses, by which an arm or foot may be exposed for from thirty to fifty minutes to a current of dry air heated to 100-150° C. and even more, and many observers (Knowsley, Sargent, Mendelsohn, Levison) have noticed the good effects of this treatment against the stiffness of gouty articulations, especially when it is combined with the use of **massage**.

To sum up, the principles of the treatment of gout are these: In all cases the **diet** is to be regulated with a view to sustain the forces of the patient without allowing any excess of food; the patient is to be advised to limit the use of alcoholic stimulants and to avoid equally excess of work and of enjoyments, whereas bodily **exercise** and **open-air life** are useful. The patient ought to drink pure water of some **aërated spring** in sufficient quantity to keep the daily excretion of urine from 3 to 4 pints; if the urine be strongly acid and liable to precipitation of uric acid crystals, the administration of small doses of some alkaline drug or spring should be resorted to to diminish the acidity and render the urine limpid.

The gouty attacks are treated by **rest**, somewhat reduced régime, **anodynes**, if necessary, and **colchicum**; in the free intervals the resin of **guaiac** will be of use. The stiffness of the gouty joints and the tophi are treated by the **dielectric introduction** of **lithia**, by the **hot-air bath**, and by **massage**.

For *chronic gouty bronchitis* the remedies on which the writer chiefly relies are pure **terebene**, in 10-minim (0.6 c.c.) doses three times a day, and **pix liquidum**, 2 grains (0.13 Gm.), made with lycopodium into a pill, of

which 2 should be taken every four hours. When the asthmatic condition is the prominent symptom **cubeb cigarettes** will be found useful.

Gouty patients often suffer from *profuse perspiration*, not at the time of the attack but chronically, and for this **picrotoxin**, the neutral principle obtained from *Anamirta paniculata*, is an infallible remedy. In the case of a bald man in whom the sweating about the head was so profuse that when he lifted his hat he was subjected to a veritable shower-bath, a pilule of $\frac{1}{60}$ grain (0.001 Gm.) of picrotoxin twice a day for a fortnight checked the distressing symptom, from which he has now been entirely free for six months. Picrotoxin is a very reliable and certain remedy for nearly all forms of sweating.

Hot baths are undoubtedly useful in many forms of gout, especially when the joints are chronically affected. To the ordinary full-length bath, containing 30 gallons, may be added $\frac{1}{2}$ ounce (15 Gm.) of pure **terebene** and 10 drops of either **pumilio pine oil** or oil of the **Eucalyptus maculata**. An **alkaline bath** may be made with 4 ounces (120 Gm.) of **bicarbonate of sodium** and 10 drops of **oil of bergamot**. A salt bath is prepared with 6 pounds (3 kg.) of bay salt and a couple of drams (8 Gm.) of bay rum. In cases of emergency a **saline bath** may be made by pouring in a couple of bottles of any of the ordinary saline purgative waters. **Mustard**, 20 ounces (620 Gm.) of the meal, and **liquor ammoniæ**, 4 ounces (120 c.c.) or more, are also useful, and common **washing soda** is often prepared under various fancy names by drug manufacturers. Murrell (Clin. Jour., May 19, 1909).

Formaldehyde, and probably also other antiseptics, taken internally, will check alimentary fermentative changes and prevent the formation of injurious by-products of digestion, thus inhibiting the onset not merely of gouty conditions, but of many others, of the precise origin of which

we are at present uncertain. McCracken (Pract., July, 1909).

The writer distinguishes three different clinical types of gout: 1. The digestive type, characterized by gastrointestinal, pancreatic, and hepatic disturbances. 2. The angionephritic type, in which vascular and renal affections play the chief part. 3. The neurotrophic type.

Each of these demands its own particular treatment. **Salicylates** and **colchicum** must be used cautiously for the paroxysms of the joint attacks. Moderate doses of colchicum must be carefully given when any of the diarthroses are affected. In attacks of the digestive type, meat must be limited, and **alkalies** given, taking **hydrochloric acid** after meals. If the action of the liver or of the pancreas is insufficient, **calomel** or **pancreatic preparations** must be ordered. The neurotrophic type calls for strict hygiene, intellectually, morally, and sexually. Le Gendre (Revue de thérap. méd.-chir., cited in Pract., July, 1909).

The uric acid is reduced by dietary restrictions and **salicylates** and **atophan**, but its elimination is not increased by quinine, colchicum, or diuretin. Alcohol, tea, and coffee cause its retention in the blood. The purin-free diet is one excluding meat, meat extracts, peas, beans, spinach, tea, coffee, and alcohol. A. F. Chase (N. Y. Med. Jour., Nov., 1916).

The excretion of calcium in the urine in gout is lower than normal, most of it leaving the body with the feces. Calcium chloride in 2 cases of gout, kept on a fixed diet, caused a marked fall in the uric acid output in the urine. This suggests that foods rich in calcium should be restricted in gout, viz., spinach, celery, rhubarb, endive, pork, cheese, and oatmeal, particularly the first four. Bain (Lancet, Mar. 31, 1917).

A visit to some spring where the application of **hot baths**, **douches**, and **massage** are combined with the use of some **aërated spring** and good vivi-

fying air will be of use to restore the forces and the spirits of the patient. Also a sojourn in some **dry and hot climate** is advisable as well for the specific gouty symptoms as for the disease of the kidneys, which is the constant companion of gout.

Fairly **bracing air** with a low relative humidity is the most suitable for the gouty. High mountain situations and damp valleys are alike unsuited. Luff (Pract., July, 1909).

Internal or Retrocedent Gout.—

The obscure symptoms of the so-called visceral gout require different treatment according to their nature, but in all cases it must be remembered that gout is only to be treated successfully when great care is given to the dietetic and hygienic treatment of the whole system. This cannot be regulated by one common rule, but it must be carefully adapted not only to each patient, but to the different stages and periods of the malady.

Tyson advises, in these cases, that efforts should be made to bring about a true external attack by means of hot mustard foot-baths, sinapisms, and similar measures. As champagne is most frequently the cause of an acute attack, indulgence in a pint of that wine has been suggested,

F. LEVISON,
Copenhagen,
AND
RAE S. DORSETT,
Philadelphia.

GRAFTING, SKIN. See SKIN-GRAFTING.

GRAIN AND VEGETABLE POISONING. See TOXIC FOODS.

GRAND MAL. See EPILEPSY.

GRANULAR LIDS. See BLEPHARITIS.

GRANULOMA. See MYCOSIS FUNGOIDES.

GRAVES'S DISEASE.—EXOPHTHALMIC GOITER, BASEDOW'S DISEASE.

DEFINITION.—Graves's disease is a chronic disorder, characterized by a great variety of signs and symptoms, the most striking of which, though not always many present, are enlargement of the thyroid gland, prominence of the eyeballs, and also tachycardia, muscular tremor, and various vasomotor disorders.

Disorders of metabolism and of local nutrition also occur, and many other manifestations, suggesting disturbances of the nervous functions, although associated with them are certain signs suggesting morphological disorders of growth, and others of myxedematous-like character, the latter occurring late in the course of the disease.

These signs and symptoms are probably due, for the most part, to a vitiation of the blood by altered or excessive secretion from the thyroid gland, but it is still uncertain whether or not there exists, behind or in conjunction with this disease of the thyroid, some special susceptibility on the part of the nervous system.

The marked nervous symptoms of the disease become plain in the light of Sajous' definition (N. Y. Med. Record, Sept. 27, 1919). Hyperthyroidism is due to a toxemia of focal (intestinal, tonsillar, dental, etc.) origin which awakens a defensive reaction of the thyroid apparatus and causes it to secrete its hormone in excess, thus provoking in all tissues, including the nervous system, correspondingly active and destructive catabolism. In cases due to emotional stress, fright, violent excitement, grief, etc., the causative poison is of cerebral origin, probably a waste, neurin, which starts a vicious circle by

causing an excessive production of thyroid hormone; the latter in turn breaks down the phosphorized fats of the cerebral and peripheral nerve cells, thus exciting violent nervous symptoms.

The order of onset of the most important symptoms of exophthalmic goiter, based on the average of the Mayo series of 2917 cases, was as follows: (1) cerebral stimulation; (2) vasomotor disturbances of the skin; (3) tremor; (4) mental irritability; (5) tachycardia; (6) loss of strength; (7) cardiac insufficiency; (8) exophthalmos; (9) diarrhea; (10) vomiting; (11) mental depression; (12) jaundice, and (13) death. Plummer (*Amer. Jour. Med. Sci.*, Dec., 1913).

Three of the 4 cardinal symptoms—tachycardia, exophthalmos and tremor—are due to abnormal innervations. Many of the symptoms now viewed as non-neural may later be found to have some neural link. It is in the vegetative nervous system that the greatest deviations from normal are found and the greatest number of symptoms of nervous origin. Among those referable to the vegetative nervous system are: Von Graefe's sign, Dalrymple's sign, protrusion of the eyeballs, epiphora, dry eyes, Loewi's phenomenon, excess or lack of saliva; asthmatic attacks, dyspnea or tachypnea; tachycardia, pulsus irregularis respiratorius, vasomotor angina, palpitation, transitory changes in blood-pressure, vasomotor skin symptoms; gastrospasm and pylorospasm, hyperacidity, hypoacidity, spastic constipation, unmotivated diarrhea and vomiting; pollakiuria, polyuria, oliguria, menstrual and lactational disturbances, disturbances of sexual libido and potentia; and profuse sweating.

The writer leans to the belief that the nervous symptoms arise chiefly as a result of the indirect effects on the higher nervous apparatus of an intoxication of the vegetative nervous system. L. F. Barker (*Jour. Amer. Med. Assoc.*, Aug. 3, 1918).

SYMPTOMS.—*Enlargement of the thyroid*, if present (which is not always the case, since it may be diseased without becoming enlarged), usually begins at about the same period with the appearance of the other symptoms, but sometimes much earlier or later.

The right lobe is commonly more prominent than the left. Vascular (arterial) murmurs of "swirring" character, obtained by auscultation directly over the gland, are probably pathognomonic when present, but are not always heard, or they may be heard over limited areas. It is doubtful whether enlargements attended with this special vascular murmur—*i.e.*, enlargements of the specific Graves-disease character—are ever present for long without other symptoms. This murmur is to be distinguished from the "hum" due to compression of the cervical veins. When one lobe of the thyroid is more enlarged than the other and one eye is also more prominent, there is usually a concurrence as regards right or left side; but marked exceptions to this rule occur, and should be noted. In spite of the presence of these murmurs, and in spite of the fact that the gland is capable of swelling with great rapidity, arterial dilatation is not a marked feature of the post-mortem changes.

A bruit over the eyeball in exophthalmic goiter is recalled by the writer as a diagnostic sign he recorded many years ago. It is a rhythmic murmur, synchronous with the pulse. The patient closes his eyes and the bell of the stethoscope is placed over the globe. A continuous hum due to the muscles of the eyelid can soon be distinguished from the bruit. David Riesman (*Jour. Amer. Med. Assoc.*, Apr. 29, 1916).

The characteristic morbid changes consist in changes in form and arrangement of the secreting cells and alteration, quantitative or qualitative, of the secretion. This is usually attended by enlargement.

Another sign emphasized by Kocher is tenderness of the thyroid.

Nervous Phenomena.—From whatever point of view we regard Graves's disease,—i.e., whether as a toxic affection or as a neurosis,—it is clear that the main part of the signs and symptoms, even many of those which are ostensibly limited to other tissues and organs, include disorders of function, or, eventually, of nutrition, of the nervous system, sometimes in all of its functions, though not necessarily all in every case.

The most common mental symptoms are excitability; restlessness, often of an agitated character; capriciousness; depression, or, on the contrary, an unnatural gaiety, with an apparent incapacity to appreciate the gravity of the situation; delirium, either in terminal stages of the disease or occurring in paroxysms during its course; typical insanity, and degenerative affections of the brain due to denutrition.

Polydipsia, excessive thirst, ravenous desire for food, and other morbid sensations of this complex sort are classifiable here. The sexual feelings are often below the normal.

Epilepsy, hysteria, and occasionally other well-defined neuroses, such as chorea and paralysis agitans, may complicate Graves's disease, and in the case of the former two affections, especially of epilepsy, the connection seems particularly close, so close that epileptic attacks are thought by some to belong to the symptomatology.

It would be premature to assume that the toxic agent at work directly excites the convulsions. This is possible, but it is more probable that the epilepsy is associated with Graves's disease, just as it may be associated with migraine or with tabes. A tissue poison of some sort, not necessarily that which is found in the thyroid, may act as the exciting cause.

We can all go back to a number of these cases and find that we have overlooked focal infections, the alveolar abscess, the imbedded tonsils, the chronic appendicitis, the gall-bladder trouble, or a chronic cystitis. J. A. McDonald (Trans. Miss. Valley Med. Assoc.; Miss. Valley Med. Jour., Sept., 1918).

An important feature in this connection must not be overlooked, however, viz., that, as Sajous has shown, it is not upon the nervous system that these various poisons act—the above list representing but a few—but upon the thyroid itself. The gland reacts under their influence to contribute to their destruction and in doing so exceeds physiologic limits. The excess of hormone produced then not only breaks down the peripheral fats, as shown by the sometimes very rapid emaciation, but also the fatty substances of the nerve cells, cerebro-central and peripheral, and thus awakens the striking nervous phenomena observed. EDITORS.

Local cramps and muscular spasms are of occasional occurrence. This tendency to spasm explains Boston's sign, which occurs as the eye is being rotated downward, following the observer's hand. The superior lid follows downward with the pupil for a short distance, where it rests for an instant, then displays a slight spasm, with apparent slipping back, after which it continues to follow the pupil for an indefinite distance.

The disease may occur without one or all of the three cardinal symp-

toms, the goiter, the exophthalmos, and tachycardia. It may be recognized by the tremor and by lid symptoms before there is any protrusion of the eyeball. If the patient gazes at some object there may be slight retraction of the upper lids; this momentary morbid retraction of the upper lids almost inevitably follows if the object gazed at is moved rapidly up and down. This may occur long before any other symptoms are apparent, and is also extremely instructive for differentiation when signs of hyperfunctioning of the thyroid suggest a suspicion of approaching exophthalmic goiter. He ascribes the lid symptom to the muscle which

The voice in Graves's disease is occasionally stridulous, weak, high-pitched, and tremulous, but one should not too hastily refer this to localized lesions causing paresis of the vocal cords. This, too, may occur, but the peculiar change of voice is, perhaps, a phenomenon of more subtle character.

Localized paralyses and atrophies belong to the rarer signs. The paralyses are analogous in general characters to those met with in tabes. In both cases there may be either transitory or relatively permanent loss of power in the muscles supplied by



Method of obtaining Boston-Kocher sign, which consists in a spasmodic contraction of the upper lid when first attempting to look at a finger.

Landström has recently demonstrated in the upper lid, innervated by sympathetic fibers. The toxic substances generated by the thyroid in excess probably act most intensely on the sympathetic nerves or ganglia, which explains the symptoms in this disease, especially the tachycardia, without objective changes in the heart. Kocher (*Correspondenzbl. f. schweizer Aerzte*, March 1, 1910).

Tremor is almost invariably present. It is fine and rapid, and usually involves the hands alone, though sometimes also the head and other parts.

Choreiform twittings are also common, suggesting the restless, jerky movements of many young girls of nervous temperament.

cranial nerves, especially the eye-muscles, and those of the face and the larynx; while the sudden, functional paraplegias of tabes are, perhaps, analogous to the "giving way of the legs" in Graves's disease.

Cases of exophthalmic goiter with paralysis of the ocular muscles. In 2 cases the paralysis involved also the muscles of swallowing or the soft palate. The writer has also compiled from the literature 40 cases of paralysis of the ocular muscles and 9 cases of actual bulbar paralysis with or without ophthalmoplegia. These bulbar cases all terminated fatally in a short time; the bulbar symptoms developed in the course of a rapid and severe Basedow syndrome. In 5 other cases the bulbar paralysis was less pronounced.

These and other cases reviewed suggest that there must be some disturbance in one or more nuclei or fibers in the medulla oblongata. Kappis (*Mitt. a. d. Grenzgeb. d. Med. u. Chir.*, Bd. xxii, Nu. 4, 1911).

One might expect that the muscles which are most prone to show weakness would be the ones most likely to become paralyzed, but this is apparently not borne out by experience. The movement of the eyes which is most often defective in Graves's disease is convergence, but paralysis may affect the external recti as well as the internal. The explanation for this discrepancy lies partly in the fact that the disorders of movement such as underlie the impairment of convergence and change of voice, which sometimes show themselves as impairing the consensual lateral movements of the two eyes, are due, partly at least, not to localized lesions, but to central disorders of co-ordination (Sattler).

Although not a common symptom of the disease, paralysis of one or more of the extraocular muscles in exophthalmic goiter is not extremely rare and should be considered a part of that disease. Möbius, Ballet, Liebreicht, Bachan and Mannheim have written interesting monographs upon the subject. The writer reports 2 personal cases. W. C. Posey (*Ophthalmic Record*, June, 1908).

Hemiplegia, in a curable form, may occur. It is not due to hemorrhage and is perhaps analogous to hysterical hemiplegia.

Cases in practice in which the severe and complete picture of exophthalmic goiter developed at intervals, accompanied by other paroxysmal phenomena indicating disturbances in both the cerebrospinal and sympathetic nerve systems. Herz (1902) reported a similar case,

the Basedow symptoms occurring intermittently in connection with vasomotor ataxia. The writer's first patient had tabes, and during his severe gastric crises all the symptoms of exophthalmic goiter developed in a pronounced form, the exophthalmos, tachycardia, sweating and tremor, and the thyroid swelled. At first all of these symptoms subsided with the gastric crisis without leaving a trace, but in time there was permanent persistence of slight exophthalmos and thyroid enlargement all the time, becoming exaggerated during the crises. In his 2 other cases the intermittent Basedow accompanied attacks of asthma. The exophthalmos, tachycardia, sweating and tremor were associated with various vasomotor symptoms, redness of the face and conjunctiva, cyanosis of the fingers, etc., and psychic disturbances,—irritability, agitation, depression, etc.,—but the thyroid did not become enlarged. One of the men had symmetrical lipomas in his neck, and these swelled notably during the attacks, but subsided again afterward, confirming the assumption of a connection between the lipomas and thyroid functioning. The same injurious influence which induced the asthma and the thyroid intoxication, manifested in the intermittent Basedow, acted on the vasomotors of the lipomas. The essential primal cause thus seems to be some irritation of the nerves regulating the secretion of the thyroid. Curschmann (*Zeit. f. klin. Med.*, Bd. lxxvi, Nu. 3-4, 1912).

Muscular atrophy, of the spinal type, rarely reaching a high degree, affecting pre-eminently the intrinsic hand-muscles, with quantitative electrical changes, and susceptible of cure, may occur. One typical case of this sort has come within my personal observation. This case was in all respects severe, but ended in almost complete recovery. This patient found great difficulty in rising from a

chair and mounting the stairs, and the gait was of a markedly waddling character.

I have, however, seen several patients who exhibited great difficulty in rising from a chair or mounting stairs, and perhaps careful search would have revealed diffuse or localized atrophy as a cause.

Cardiac Signs.—The most common of these is tachycardia, not easily controlled by digitalis, and associated with excitability, often irregularity, and palpitation.

Any case which has tachycardia and extreme nervousness should arouse a suspicion of exophthalmic goiter. While exophthalmos is a striking symptom, it is one of the least important, as the patient suffers more from tachycardia, nervousness, and tremor. Robey (Boston Med. and Surg. Jour., May 5, 1910).

In the writer's 4 cases of acute exophthalmic goiter there were only 2 constant symptoms, tachycardia and rapid and excessive loss of weight. In no other disease does the patient lose so rapidly in weight—in a case of Schlesinger's, 122 pounds in eleven weeks; in 1 of the writer's patients, 48 pounds in a few days; another, 110 pounds in a few months. There was no enlargement of the thyroid in 2 cases and none in the beginning in another case in which later a large goiter developed. The tachycardia was constant and in some became a perpetual irregular arrhythmia; the blood-pressure also ran up extremely high and in one of the cases has persisted high, although there was nothing to indicate kidney disease. R. V. Funke (Zentralbl. f. innere Med., July 12, 1913).

Secondary dilatation is frequent, and with it loud systolic murmurs. True endocarditis is not characteristic, and even conditions which seem serious may disappear if the progress of the case is otherwise favorable.

In the last 600 cases observed by the writer, tachycardia was present and was referable to no other cause, with history of decided palpitation, paroxysmal and disturbing. The great majority showed either a visible fullness of the thyroid gland or at least a decidedly greater than normal fullness on palpation. In a few cases only was the thyroid not palpable with ease, when the tremor and ocular signs were present, *i.e.*, in 54.8 per cent. Sawyer (N. Y. Med. Jour., July 13, 1907).

The pulse rate frequently reaches 150, occasionally 200 or more, especially during attacks of palpitation. These attacks can occur without apparent cause and often at night, and may be of alarming and even fatal severity, and cause terrible distress, though in fact death rarely occurs in them. Möbius long ago suggested that the apparently causeless occurrence of these seizures marks them as probably of toxic origin; but if this is sound reasoning it must be extended to embrace many cases of tachycardia in neurasthenia and hysteria and in the "*Angst*—" neuroses which are indirectly of sexual origin (sexual abstinence with excitement, etc.).

Vasomotor Phenomena.—Flushing and high vascularity of the skin, "dermatography," and pulsation of the larger arteries, especially the carotids, are very common. Less often noted, but calling for further study, are pulsation of the abdominal organs and vascular dilatation confined to localized areas.

An association between Raynaud's disease and exophthalmic goiter is pointed out by the writer upon the basis of a personal case. The patient was a young woman 22 years of age, of a low order of intelligence who as a child of 6 years had suffered from a peculiar affection of the

hands, with a change of color of the skin, from red to purple and grayish blue; a sensation of cold, up to impossibility of moving the extremities; "dead fingers," alternating with local cyanosis, etc. The patient presented a swelling of the neck, but no actual goiter. The heart dullness was increased; exophthalmos was more marked on the right than on the left side. The symptom of tremor was noted, and the eyelids showed Stellwag's and Möbius's signs. Angelo (II Policlinico, May, 1908).

The radial pulse may feel weak and thready even when the carotids are beating strongly. The dilatations are due to influences acting on the affected portions of the blood-vessels, and not to general increase of blood-pressure, which is not, in fact, characteristic. In general, the blood-pressure is low. Arterial pulsation may be seen in the fundus of the eye, but this sign, as well as tortuosity of the veins near the disk, is often looked for in vain. Local gangrene has occasionally been noted.

Edemas occur and are usually of the non-pitting sort. They are sometimes due to localized circulatory changes, sometimes to cardiac weakness, sometimes, perhaps, to a myxedematous tendency, and sometimes to unknown causes. The eyelids, one or both, are prone to this edema, and may remain affected even when the patient is otherwise doing well.

Albuminuria, which is usually transitory, may occur and should be watched for. General edema, not due to cardiac weakness, may be a striking feature of early stages of the disease (Mackenzie). A non-pitting edema of the legs or of the abdominal walls may occur, suggesting myxedematous edema, but not influenced by thyroid treatment.

Hyperplasia of the neighboring lymphatic organs is liable to develop in consequence of the progressive hyperthyroidism and thyroid intoxication, this hyperplasia being most evident in the thymus, lymph-glands, in heteroplastic lymphomas in the thyroid itself, or in the spleen and bone-marrow. Graupner (Münch. med. Woch., Aug. 9, 1910).

Case of paradoxical albuminuria and urobilinuria accompanying a mitral and tricuspid defect, cirrhosis of the liver, enlarged spleen, and symptoms of exophthalmic goiter. The writer ascribes the syndrome to the abnormal conditions in the circulation from the valvular defects. This was confirmed by the results of digitalis treatment both in this and in a second case. The venous engorgement had induced cirrhosis in the liver, with resulting urobilinuria; in the kidneys it had induced albuminuria, and in the thyroid it had induced excessive functioning. Staunig (Wiener klin. Woch., Feb. 29, 1912).

Maude has described fugitive puffy swellings as occurring in various parts, as the face, neck, arms, etc.

Irregular and inadequate innervation of the circulatory system undoubtedly accentuates or causes other disturbances, such as the diarrhea, the sweating, the exophthalmos, the epistaxis, and other hemorrhages from the mucous membranes.

The digestive disturbances in the writer's last 600 cases were of manifold variety, but in many cases furnished a large part of the patients' complaint. All degrees of disturbed secretion from achlorhydria to high hyperchlorhydria secretion of typical gastrosuccorrheal type were present. Moreover, these patients on repeated tests showed very variable composition of stomach contents as to chemical and ferment activities. Sawyer (N. Y. Med. Jour., July 15, 1907).

Case in which the intestinal disturbances so overshadowed the other

symptoms that the patient, a laborer of 36 years, was sent to a surgical clinic for a more accurate diagnosis of his bowel trouble. Nothing wrong was found in the abdomen, but, as the man had slight but typical symptoms of Graves's disease, half of the thyroid was removed and the diarrhea stopped at once. The other symptoms also disappeared, though more gradually. The diarrhea was

Not only are dyspnea and a sense of suffocation present during attacks of palpitation, but a diminished inspiratory capacity is sometimes to be noted as an early symptom and may remain throughout the illness.

Ocular Signs.—Paralyses of the eye-muscles have already been referred to as among the affections of the nervous

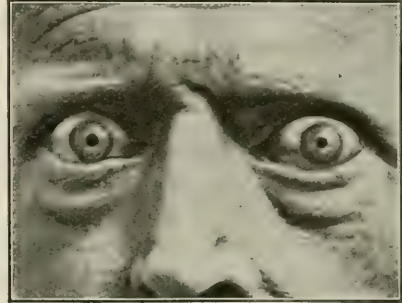


Illustration of method of obtaining von Graefe's sign, which consists in lagging of the upper lid when the finger is followed from above downward. (*Boston.*)

of a nervous type and Schmieden thinks it was due to an overstimulation of the sympathetic by the thyroid secretion. Schmieden (*Deut. med. Woch.*, 33, p. 1571, 1912).

Case of a man, 45 years old, who was operated on for a large substernal goiter. For the past fifteen years he had had severe unappeasable attacks of diarrhea which ceased promptly after the strumectomy. This relief, setting in immediately after operation, proved that the diarrheas were occasioned by Basedow's disease. Kolb (*Münch. med. Woch.*, Dec. 3, 1912).

system. Besides these, the most characteristic signs are retraction of the lids (Stellwag's sign), exophthalmos, and the impairment of the power of convergence. Graefe's sign (lagging of the upper lid when the globe moves downward) and impairment of the wink-reflex are directly traceable to the retraction of the upper lid. In 600 cases studied by Sawyer 54.8 per cent. had shown one or more of the ocular signs, usually von Graefe's, and tremor of the type described by Marie.

The writer noted a definite exophthalmos in exhausted soldiers; it was present in the early stage of advanced conditions of exhaustion, and was only temporary, lasting usually 2 or 3 weeks. When it disappeared the patient at once merged into the group of cases labelled "neurasthenia," and was indistinguishable from them. It is probable that a large number of so-called psychoneuroses are cases in which the symptoms are due to a state of disordered internal secretion, the result largely of emotional exhaustion, and, to a less degree, of physical exhaustion. Many cases later diagnosed irritable heart, D. A. H., soldier's heart, and neurasthenia, are cases of this class. W. Johnson (Brit. Med. Jour., Mar. 22, 1919).

This retraction of the lid may be present without exophthalmos, the staring appearance giving a false impression of protrusion. The lid signs may vary in intensity from day to day. The protrusion itself is generally present in greater or less degree, sometimes, though very rarely, to such an extent that the eye is nearly or quite dislocated from the socket, yet the movements of the globes remain consensual and double vision is not characteristic.

The protrusion may come on rapidly and may subside as rapidly, showing that it is due to congestion, perhaps associated with muscular relaxation. Later, it becomes fixed and is referable in part to accumulation of fat in the orbit. It is often greater on one side than the other, the right globe being usually the more prominent.

Unilateral exophthalmos in Graves's disease is of rare occurrence. The authors have collected 112 cases.

In Case I, left-sided exophthalmos was associated with enlargement of the left lobe of the thyroid. In Case II, the ocular phenomena were right-sided, but the goiter was symmetrical.

G. Worms and A. Hamant (Gaz. des hôpitaux, June 20, 1912).

The right lobe of the thyroid, as already stated, is likewise usually more prominent than the left, and the conclusion almost forces itself on the mind that the two phenomena are in some way related. It occasionally happens, however, that the larger lobe of the thyroid and the more protruding eye are on opposite sides. The failure of the lids to cover the eyeball prepares the way for ulcerations of the cornea, though it seems probable other influences prevail, for exposure alone does not always explain it.

The infrequent winking, sometimes not more than two or three times a minute, is of the next importance to Graefe's sign. Difficult convergence and Gifford's sign (difficulty in everting the upper eyelid) are also discernible in a small proportion of cases.

Sensory disorders are not characteristic except those which are related to the general feelings of malaise. Many others occur in individual cases, but they are largely signs of concomitant neuroses.

Nutrition.—Patients having the acute form usually grow thin and weak, while excess of phosphates and urea appear in the urine. On the other hand, in mild or even in rather serious cases the weight may remain unchanged or may even increase.

Toward the close of life in fatal cases, and even at an earlier period, a sort of cachexia may come on which obstinately resists treatment.

It is worthy of note in this connection that obesity, in otherwise-healthy persons, is not always overcome by thyroid preparations, and that different persons react very differently as regards loss of weight.

Case of exophthalmic goiter with symmetrical lipomatosis: The masses occurred on both sides of the body, on the back of the neck, mammary areas, abdomen, back, arms, and thighs. The limbs were increased to twice their natural size, the rest of the body being emaciated. The diagnosis of exophthalmic goiter was confirmed by marked exophthalmos with the positive von Graefe, Stellwag, and Möbius signs, the enlarged thyroid and rapid pulse, tremors and extreme nervousness. L. Neuwelt (Jour. Amer. Med. Assoc., Jan. 20, 1912).

There are some types of alopecia, usually most chronic and resistant to treatment, which appear to be directly related to Basedow's disease; some of them are aggravated by its onset; others improve as the classical symptoms of the syndrome develop; children of the patients with exophthalmic goiter present evidence at times of a thyroid inefficiency, and may develop alopecia without vitiligo, or vitiligo without alopecia; we know nothing definite concerning the relations of the various thyroid symptoms with alopecia, except that such relations undoubtedly exist; it is remarkable that, although we are ignorant of the immediate causation of alopecia, we cannot deny the genetic influences of two great "internal-secretion" glands—the ovary and the thyroid body. Sabouraud (Ann. de derm. et de syph.; Can. Pract. and Rev., Sept., 1913).

Miscellaneous Symptoms.—Alimentary glycosuria, sugar appearing in the urine within a few hours after taking grape-sugar or glucose (the usual test-dose being 100 Gm.—3½ ounces), is relatively common among patients with Graves's disease, though this peculiarity is shared by the subjects of various other neuroses.

True diabetes mellitus is also relatively common among them, though, in fact, rare.

Four cases in which exophthalmic goiter was accompanied or succeeded by a severe form of diabetes. One patient recovered from a typical attack of exophthalmic goiter, which was, however, followed by a severe form of pancreatic diabetes, to which she succumbed. The disappearance of the exophthalmic goiter was evidently due to the return of the thyroid to a normal condition, and is an interesting example of how complete this recovery of the gland may be. The diabetes was the result of the destruction of the islands of Langerhans. G. R. Murray (Clinical Jour., July 28, 1909).

Feverishness (increased internal temperature) may be present during the acute stage, but by no means in proportion to the sense of heat, which may be of vasomotor, or of purely neurotic, origin.

Case in which the general malaise, headache, nausea, a typhoid tongue, sordes on tongue, and enlarged spleen suggested typhoid fever. When first seen the patient had had a temperature varying between 102° and 103.5° F. (38.9° to 39.7° C.) for about eleven days, but the Widal tests were negative, and on the twelfth day the temperature came down to 98.6° F. (37° C.). Dlugasch (Med. Rec., Oct. 29, 1910).

Icterus, salivation, and digestive disorders, such as diarrhea and vomiting, which will be referred to separately, belong to the symptomatology of Graves's disease, the diarrhea being especially common. This diarrhea is usually not due to fermentative changes, but to anomalies of secretion and peristaltic action, either based upon disorders of innervation or indicating the elimination by the intestine of some toxic substance. Sometimes the stools are simply liquid, sometimes they are peculiar in character. Cholesterin has been found

in considerable quantity, and in the case of a patient of mine a number of whitish masses were excreted, the character of which was not ascertained.

A marked lymphocytosis exists in all cases, according to Kocher, a phenomenon now attributed to active participation of the thymus in the morbid process.

The writer has called attention to the importance of changes in the blood as an early sign of exophthalmic goiter; the leucocytes are only half as numerous as usual, the neutrophils being much reduced, while the lymphocytes are twice the normal figure. Kottmann has also called attention to a reduction in the coagulating power of the blood in this disease, in contrast to what is observed in myxedema; with cachexia thyreopriva coagulation is accelerated. The absence of anemia in the Basedow syndrome is in itself a striking finding. The writer regards the disturbance in the blood picture as so constant and regular that he refuses to operate in its absence. Kocher (*Correspondenzbl. f. schweizer Aërzte*, March 1, 1910).

Beebe having called attention to the fact that he had not found confirmation of Kocher's statement that there was a marked lymphocytosis in these cases of hyperthyroidia, the writer, since Kocher's first statement some years ago, had made a number of differential counts on about 800 cases of exophthalmic goiter and simple goiter as well. He had analyzed all the 27 deaths which had occurred in exophthalmic goiter. Not one gave a high lymphocyte count. Of the 25 in which a high lymphocyte count was given, not one had been a severe case. It was true that in exophthalmic goiter there were a great many cases with a relatively high lymphocytosis up to 40 per cent., but it was equally true that in simple goiter they had equally high lymphocytosis. L. B.

Wilson (*N. Y. Med. Jour.*, Dec. 28, 1912).

Vomiting may occur in attacks suggesting those of tabes, but usually without pain.

Signs of impaired local nutrition may be present in the form of swellings of the joints, as of the fingers; ulcerations of the cornea,—due partly, but not wholly, to exposure arising from the wide lid-openings,—and various affections of the skin and its appendages, as vitiligo, bronze pigmentation, inflammation about the nails, scleroderma, sweating, erythema, urticaria, and leucoderma.

Among the symptoms affecting the skin-organ may be named: pruritus, hyperidrosis, and hydrocystoma, erythematous flushing, scleroderma, myxedema, and, lastly, telangiectasis. Personal cases illustrating the fact that the telangiectatic and other blood-vascular lesions of the skin, in the subjects of exophthalmic goiter, may develop after the chief thyrotoxic phenomena have vanished. Hyde (*Brit. Jour. of Dermat.*, Feb., 1908).

Patches of dark-brown pigmentation were observed by the author over the entire body; in another case localized lipomatosis was a striking feature of the exophthalmic strumous tachycardia, as he prefers to call exophthalmic goiter. In other patients he has observed pigmentation similar to that of Addison's disease. The writer refers to Löwi's recent researches which demonstrated the existence of mutual relations between the organs with internal secretion, evidenced by pupillary phenomena. He thinks that these facts suggest the participation of the suprarenals in the syndrome of exophthalmic goiter, while the parathyroid glands have nothing to do with it. Von Schrötter (*Med. Klinik*, April 5, 1908).

Alopecia is not uncommon; the hair of the eyebrows is also apt to fall, beginning with the outer halves.

Among the physical signs which the writer noted in his last 600 cases was, quite frequently, a peculiar distribution of hair. In a great number of these cases the eyebrows are very scanty, either throughout their whole extent or especially in the outer half of the brow, lashes scanty; oftentimes the axillæ are more than usually free from hair, as also over the legs the usual growth is absent. Moreover, the hair of the head in many of these patients seems to be divided into two zones; and the lower and narrower zone running around the lower edge of the growth of the hair of the temporal and occipital regions is apt to show a gray zone, sometimes a fringe of white, before a change of color is noticeable in the superior zone; or, in younger patients, this zone of hair is scanty. In a few patients he has seen this peculiarity of pigment reversed. This one feature has often suggested to the writer the probable existence of exophthalmic goiter in the lesser forms and has caused him to look for other recognizable signs of hypothyroidism.

He also calls attention to the importance of the vasomotor disturbances with relation to the surrounding atmospheric conditions, and suggests the likelihood of all the paroxysmal phenomena in a given case being precipitated by the existence of a high relative humidity. Sawyer (*N. Y. Med. Jour.*, July 13, 1907).

Attention is called by the author to the occurrence of a congenital form of frontal band alopecia which appears possibly to be related to exophthalmic goiter on the one hand, and on the other to certain signs and symptoms connected with that disease.

Hairlessness in the frontal region is characteristic of infants; its persistence into later life constitutes the congenital frontal band alopecia or congenital high forehead. It is far more frequent in girls than in boys. The band may be quite bald. D. Walsh (*Lancet*, Oct. 19, 1907).

The fingers may become tapering and very movable in their articulations. It is possible that changes of this character, and others met with in Graves's disease, indicate changes in morphological tendencies of growth such as occur in myxedema and after castration.

The spleen and lymph-glands may become enlarged to the point of lymphadenoma (Gowers). The thymus is often persistent.

The uterus and the breasts—one or both—may atrophy prematurely, or, on the other hand, the breasts may enlarge. Basedow reported a case of this sort in a man.

The bones may become soft and it is said (Revilliod) that symptoms like those of Graves's disease may occur in osteomalacia.

Myxedematous changes occur as a sequel to the thyroid atrophy which may follow the Graves-disease degeneration of the thyroid gland, and many cases have been reported which indicate that these two, apparently opposed, disorders may occur in conjunction with one another. The sorts of myxedematous changes most likely to occur are non-pitting edema, supraclavicular swellings, scleroderma, falling of the hair, mental dullness, atrophy of the breasts, disease of the bones and joints, dryness of the skin.

DIAGNOSIS.—There is no difficulty in the diagnosis of a typical case of Graves's disease. On the other hand, in the early stages of very mild cases one may be able to do no more than suspect the presence of the trouble; yet this suspicion may be of great practical importance. There is, perhaps, no single symptom which may not be absent or so inconspicuous as not to challenge attention. Even

the rapid pulse may, perhaps, be lacking. This is extremely rare, but pulse rates of about ninety are not very uncommon. Persistent tachycardia of any grade; persistent nervousness, agitation, and tremor, not associated with typical signs of neurasthenia or hysteria, or out of proportion to those signs; persistent—even if slight—suffusion of the face, and causeless diarrhea should always awaken suspicion, and, if the patient has had an indolent goiter for some years or has been recently exposed to severe emotional excitement or any of the other exciting causes of Graves's disease, there will be all the more reason for thinking that the suspicion is well grounded. High temperature, sweating, and loss of flesh would all be confirmatory indications, but the presence of well-marked signs of hysteria or neurasthenia might, in the absence of an enlargement of the thyroid, offer another and sufficient explanation.

The most striking symptom is the rapid loss of weight; this is more rapidly extreme than even with cancer. One such patient lost 44 pounds in a month, another 66 pounds in ten weeks, and in a recent case the patient's weight dropped from 189 to 61 pounds—a loss of two-thirds of her weight in eleven weeks. Another frequent symptom is enlargement of the spleen. Fever is more common in acute than in chronic Basedow's disease. In acute cases the thyroid may be normal in appearance or even smaller than usual, but auscultation reveals the vascular murmurs of Basedow's disease. Schlesinger (*Therap. der Gegenwart*, Nov., 1912).

Tests for the Detection of Hyperthyroidism.—In most cases of hyperthyroidism, with or without goiter, or its more severe form, Graves's disease, the diagnosis is readily established. In borderline cases, however, this is

sometimes possible only with the aid of tests—provided the latter are absolutely reliable. None can still be said to merit this title.

The *thyroid test* based upon the use of thyroid preparations to see whether the patient will or will not show a more or less sudden exacerbation of all symptoms—if hyperthyroidism be already present—should not be used, as it may prove sufficient to transform a borderline case (which might, as is often the case, have proven benign under treatment), into one far more difficult to control.

The *Goetsch adrenalin test* is based on the fact that patients with hyperthyroidism are abnormally sensitive to adrenalin administered subcutaneously, 0.5 Gm. ($7\frac{1}{2}$ m.) of the $\frac{1}{1000}$ solution being used. If positive, there occurs an increase of blood pressure and aggravation of the characteristic symptoms of the disease. This test is preferable to the former, for it does not tend to aggravate the morbid process. It is described in Volume I, page 704.

In a personal case of many years' standing, the injection of adrenalin raised the pulse frequency from 106 to 130 and the blood-pressure from 145 to 175. After removal of one-half of the thyroid the increases were: pulse 80 to 88, blood-pressure 130 to 135. In a severe case with relatively low pulse and blood-pressure, the provocative injection caused an increase of pulse from 98 to 128 and of blood-pressure from 145 to 228. But after ligation and subsequent thyroidectomy the test was no less positive than before, although patient had rapidly improved and had gained 17 kilograms. The results in general do not appear to show any definite necessary relationship between adrenalin hypersensitiveness and the degree of severity of Graves's disease. Troell (*Hygiea*, Jan. 31, 1920).

The *basal metabolism* is doubtless the best at our disposal at the present time. Its purpose is to ascertain the minimum heat production of the body during 12 to 18 hours' complete rest after taking food. It may be measured by means of the Benedict type of gasometer, but the small portable apparatus based on the Tissot method has been found more satisfactory. In hyperthyroidism the metabolic rate may be found increased 50, 80 or even 100 per cent., while in hypothyroidism it may fall below normal by 20 or 30 per cent. Here again, however, elements of error are introduced by the fact that adrenalin, for instance, is capable of increasing the metabolic rate. The functions of the adrenals being increased in many diseases, errors in diagnosis become possible. Again, there is a suggestive disparity between the adrenalin and basal metabolism tests.

In a comparison of various tests in 11 cases, the writer found the *epinephrin test* clear, positive, and of moderate degree in 6 cases; clear, positive, and of more marked degree in 5; and the *basal metabolism test*: 1 per cent. high; 6 per cent. low; 5 per cent. high; 8 per cent. high; 8 per cent. high; 20 per cent. low; 4.5 per cent. low; 14 per cent. low; 2 per cent. high; 7 per cent. high; and 1, flat normal. On section, the 11 thyroids all showed definite abnormalities of a type suggesting functional overactivity. Woodbury (Jour. Amer. Med. Assoc., lxxiv, 997, 1920).

Other tests, such as *digitalis*, *complement fixation*, *hyperglycemia*, *pituitary* and *quinine tests*, have been proposed but none have as yet been demonstrated to possess the degree of certainty which a diagnostic method must show to merit confidence.

ETIOLOGY.—Graves's disease is found among men and among women, and even among animals, and may occur in childhood,—even infancy,—in adolescence, in adult life, and rarely in old age. It is, however, far more common among women than among men, and almost always shows itself first during early adult life.

No race is wholly exempt, nor the inhabitants of any special country, and none are very much more prone to the disease than the others. Every now and then the claim is made that it is especially common in one or another place or section of country, but this is not borne out by prolonged investigation and is probably an example of the accidental coincidences in which the history of medicine abounds.

On the other hand, there is rather more reason to think that Graves's disease is more common in districts where simple goiter is endemic. If this should prove true the fact would harmonize with the observation that the special kind of goitrous affection met with in Graves's disease is more likely to occur on a basis of thyroid disease of other sorts than on a basis of health. On the other hand, this relative frequency of Graves's disease in goitrous districts is only relative, and its causes are not clear, unless we adopt one of the theories which ascribe the disease to intoxication, with excessive activity of the thyroid as result. The fact that iodine, the active agent in the thyroid, can awaken the disease, thus simulating thyroid overactivity, tends to support this view.

Two cases of Graves's disease were due to therapeutic administration of iodine. The resulting disturbances are not the comparatively harmless

and transient symptoms of iodism; on the contrary, the iodine seems to exert in these cases a specifically injurious action on the thyroid which persists after suspension and elimination of the drug. This is liable to occur whether the thyroid is perceptibly pathological or not, especially with serous meningitis and incipient tabes, as well as with goiter and atherosclerosis. These iodine disturbances are not restricted to regions where goiter is prevalent. Goldflam (Berl. klin. Woch., March 6, 1911).

Basedow's disease can and has been produced experimentally in lower animals by the injection of thyroid pressure fluid, by the implantation of the thymus gland, and by the injection of the macerated thyroid gland. Gland symptoms resembling Basedow's disease can be produced in animals by thyroid feeding. The evidence at hand indicated the close relationship between the thymus and thyroid gland. The symptoms of Basedow's disease are due either to an excess or to a perverted secretion of the thyroid gland, with the primary disturbance existing in the thymus gland, the action of the thyroid being that of a multiplier, according to the theory of Mikulicz. Basedow's disease has been produced in man by the excessive administration of thyroid extracts and preparations of iodine. J. H. Jacobson (N. Y. Med. Jour., March 15, 1913).

Modern studies of the various ductless glands have suggested numerous explanations of the manner in which the disease is caused. Besides Möbius's conception, which still holds good in the opinion of most observers, that the disease is due to excessive secretory activity of the thyroid gland, and the nervous theory, in which irritation of the sympathetic system is considered the exciting factor (Kobens), we must now take into account a number of new theories, which include other ductless glands.

Among the more solid may be mentioned the thyrogenital theory, based on the familiar relationship between the thyroid gland and the ovaries, which accounts for the development of the disease in predisposed women during physiological or operative menopause; the thyrohypophyseal theory (Salmon), based on the belief that the secretion of the pituitary body contracts the thyroid, and that a destructive lesion of the former causes enlargement of the latter; the thyrothymic theory (Markham), in which the enlargement and overactivity of the thymus is regarded as the pathogenic agent; the thyropancreoadrenal theory (Eppinger, Falta, and Rudinger), in which hyperthyroidism is thought to cause excessive adrenal activity, and inhibition of the pancreas; the neurothyro-adrenal theory (Sajous), in which the morbid process is ascribed to excitation, by endogenous or exogenous poisons, or by shock, physical or emotional, of the centers which govern the thyroid and adrenal glands, with resulting overactivity of both these organs.

In addition might be mentioned the autointoxication theory, which ascribes the symptom-complex of the disease to the absorption of toxic products from the intestinal canal, with the thyroid playing no, or a secondary rôle in the process (W. H. Thomson).

The writer has performed 721 operations in 535 cases of Graves's disease. He has always found histological changes in the thyroid gland, likewise a hypersecretion, and in this an increased iodine content. Symptoms of Basedow's disease could be experimentally produced in animals by the injection of thyroid extract, thyroid substance, or iodothyreoidin. Apparently the assumption that the disease is a hyperthy-

roidism is correct. The fact that iodine therapy regularly increases the severity of the symptoms substantiates this. T. Kocher (*Deut. Gesellschaft f. Chir.*, Bd. xl, 1911).

Three cases in which Graves's symptoms developed in the course of iodine or thyroid treatment of a goiter. In one case the symptoms persisted long after the treatment had been suspended. Pulawski (*Med. Klinik*, July 28, 1912).

Primary Cause.—The prevailing view, which is steadily gaining ground as experience accumulates is that the primary pathogenic agent originates in a localized morbid process, the tonsils, the teeth, the alimentary canal, the nose or sinuses, chronic appendicitis, gall bladder disease, chronic cystitis, pyogenic disease of the uterus, etc. This may either cause hyperthyroidism or aggravate the morbid influence of an existing goiter. Its adoption does not modify materially our conception of the nature and symptomatology of Graves's disease. The most that can be inferred is that it was acting, at the moment of its removal, as a considerable cause of nervous instability, either general or local, or perhaps central in the light of Sajous's theory.

A large percentage of patients with exophthalmic goiter have enlarged tonsils and adenoids, and give a history of repeated attacks of acute tonsillitis. It is not uncommon for them to date the beginning of the goiter to one of these. Infections of the nose and throat are undoubtedly the commonest to which man is subject, and many of our ills might, if one was so disposed, be credited to them. If, as held by Sajous, the thyroid secretion is an important element against infections it is not impossible that it is stimulated to overactivity when occasion calls for it, and if this is too often repeated the gland may become enlarged and a pathologic condition

induced. It is not a rare thing to find that a rapid enlargement of the thyroid with characteristic symptoms of overactivity has immediately followed a particularly severe tonsillar infection. S. P. Beebe (*Jour. Amer. Med. Assoc.*, Aug. 29, 1914).

In 52 patients treated by the writer, some infection was present in the mouth, tongue, teeth, nose, tonsils, pharynx or larynx. In 35, when the infection prevailed on the right side, the right lobe was more enlarged than the left, and in 10 with infection left-sided, enlargement of the left lobe was noted. S. R. Pietrowicz (*Jour. Amer. Med. Assoc.*, Jan. 8, 1916).

"Secondary" cases of Graves's disease are liable to become as severe and as complex as "primary" cases, and when both are fully developed there is no criterion by which we can distinguish between them. Neither is such a criterion furnished by differences in their modes of onset, since in some of the cases which would be designated as "primary" the symptoms come on very slowly, while, on the other hand, in any class of cases a slow progression or incomplete symptom-complex is liable to give place suddenly to a rapid development.

One important group of cases is that where the symptoms of Graves's disease are actually complicated by those of the state often designated as an "opposite" one, that, namely, of true, though partial, myxedema. Such symptoms are mental dullness, non-pitting edema, perhaps low temperature, and falling of the hair.

This condition, according to Sajous, is true myxedema due to exhaustion of the thyroid apparatus, or to degenerative changes in its secreting elements. The participation of other ductless glands in the degenerative process is further shown by the presence of bronzing, which denotes adrenal failure, adipositas, showing pituit-

ary failure, etc., in some cases—the few that live long enough, untreated, to attain this stage. EDITORS.

On the whole, it is beyond question (1) that the thyroid functions are closely related to those of all the other ductless glands; (2) that, especially during periods of growth and involution, symptoms of defect or abnormality of nervous action may be present which are traceable to the causes mentioned.

The differences based on mildness or severity, completeness or incompleteness of the clinical picture, etc., although not of radical importance, and not suited to form a basis for classification, are, nevertheless, of great interest. In some cases the symptoms reach in a few days, or even hours, a degree of development for which, in other cases, years had been required. Even a fatal ending may occur in the course of days or weeks.

These acute forms are apt to develop under the influence of nervous shock or fright, and this is of particular importance from the fact that there is a close analogy (symptomatically and possibly etiologically) between the Graves disease-complex and the fright-complex. Fright is, after all, the exaggeration of a normal or quasinormal state, and the secretion of the thyroid may be important for the maintenance of the latter, but excessive or altered in the former.

During the war the writer has met a relatively large number of cases in men from 20 to 45 years of age. Some had had small goiters, but the exophthalmic symptoms followed physical or mental overwork, intoxication from poor food or water, or microbic infections—dysentery, typhoid, or paratyphoid—in the form of light attacks of thyroiditis. In 3 cases exophthalmic goiter appeared

suddenly, following violent emotions, repeated anxiety, or strenuous exertions. In a few days these subjects found their necks growing larger, eyes protruding, pulse rate increasing, and mental state exhibiting restlessness and anxiety. All 3 had diarrhea and lost considerable weight. Léon Bérard (Bull. de l'Acad. de méd., Nov. 28, 1916).

There can be no doubt but that Graves's disease is more common in neuropathic families and among neuropathic persons than in connection with sound health, and it is equally certain that it often develops rapidly after exposure to fright, prolonged anxiety or excitement, profound grief, or after physiological strains such as draw strongly on the resources of the nervous system.

Three cases of Graves's disease in the same family, a brother and sister in the fifties, and a niece of 25. The family history showed that the older patients had apparently healthy parents, but an uncle and his son had diabetes. They had further 2 healthy brothers, but the children of 1 brother included the niece with exophthalmic goiter and 1 epileptic, while 4 died young. Grober (Med. Klinik, Aug. 16, 1908).

Among the causes of this order are influences associated with *pregnancy* and *childbirth*. It has, to be sure, been thought that another explanation was nearer,—namely, that based on some special relationship between the functions of the thyroid and those of the generative organs. Both pregnancy and childbirth may excite or aggravate or, on the other hand, lessen the symptoms of exophthalmic goiter. Inasmuch as overactivity of the thyroid gland accompanies pregnancy, it is probable that in the former the abnormal activity is perpetuated after parturition, while lessening of the morbid process after

childbirth may be due to exhaustion of the organ and the resulting arrest of its excessive activity.

Two cases of pregnancy complicated with exophthalmic goiter, 1 in a *tertiopara*, the other in a *primipara*; the women were delivered at term; the 1 had no sequelæ, while in the other dilatation of the right heart, exophthalmos, and enlarged thyroid persisted. It is a rare occurrence; only 3 cases were found in 45,000 women. E. Bonnaire (*La Presse méd.*, April 6, 1910).

A case of congenital hereditary Graves's disease. The mother was a *primipara*, aged 23 years, in whom developed symptoms of the disease when she was five months pregnant. The condition later became progressively more marked. The fetal heart rate at the onset of labor was not precisely countable, but was well over 200 a minute. Upon delivery the child exhibited all the features of the disease present in the mother. The eyes were prominent and staring, and the thyroid showed a well-marked, uniform enlargement. The heart beats were uncountable, and a loud systolic murmur was heard over the precordium. There was also a fine tremor of the hands. The child remained markedly cyanosed and died thirty-four hours after birth. The thyroid, after removal from the body and hardening, measured 3.5 cm. transversely, 2.9 cm. perpendicularly.

The writer was unable to find record of any similar case in the literature, the youngest case of exophthalmic goiter reported being that of Ochsner and Thompson, in a child aged 5 months. White (*Proceed. Royal Soc. of Med.*, April, 1912).

Exophthalmic goiter in pregnancy is rare, on account of the restraining influence of the disease upon conception. Goiters have been attributed to pregnancy, but they are more probably due to beginning hyperthyroidism. Thyroidectomized dogs produce

pups with thyroids many times normal size, while pups of mothers with colloid goiters have normal thyroids. No mother with a normal thyroid gives birth to goitrous pups. In thyroidless sheep iodine restores a healthy condition. Physiological enlargement of the thyroid in pregnancy is noted more in patients living in goitrous districts, but also in non-goitrous communities more than is generally supposed. L. F. Watson (*Trans. Amer. Med. Assoc.; Med. Rec.*, June 22, 1918).

In 1586 pregnancies the writer noted 132 goiters, only 8 of which were toxic or of the hyperthyroid types. In 28 years he has had under supervision 100,000 cases and had never heard of operative interference for hyperthyroidism, except in 1 case, in which he operated personally. The woman was expecting her ninth child. She had previously had the right lobe of the thyroid removed. During this pregnancy she was really suffering from pressure of bands across the trachea. The left lobe of the thyroid was removed with complete relief of symptoms. The writer does not think pregnancy increases the symptoms of simple thyroidism. The hygienic surroundings and treatment of the patient play a large part. J. W. Markoe (*Trans. Amer. Med. Assoc.; Med. Rec.*, June 22, 1918).

Accidents, particularly blows on the head, have been known to cause exophthalmic goiter, probably in subjects predisposed to neuropathic disorders.

Three cases of exophthalmic goiter developing after an accident. In 2 cases a predisposition was evident, with stigmata of hysteria. In the third case, however, a man in apparently perfect health was involved in an automobile-street-car accident, and two or three weeks after the physical pain had subsided nervous symptoms developed and, six months later, symptoms of exophthalmic goiter. Dyrenfurth (*Deut. med. Woch.*, Nov. 21, 1912).

The writer observed 3 cases of typical exophthalmic goiter in military men thrown from a horse or falling from a wagon. Each had fallen on his head, and after 1, 2 and 3 months the symptoms developed. In several other instances, trauma to the head caused symptoms suggesting hyperthyroidism, particularly a slight exophthalmos. Léniez (*Progress méd.*, Nov. 20, 1916).

Chlorosis has been frequently assigned as a cause of Graves's disease, and indeed the two affections are often enough seen in conjunction. But the fact that so careful a student of chlorosis as von Noorden asserts that he has not been able to detect any such relationship shows that it cannot be a very important one. On the other hand, the impossibility, at present, of assigning the true cause for every outbreak of Graves's disease is well illustrated by the history of an acute case, which ran its whole course, to recovery, while the patient was under observation in von Noorden's clinic and apparently free from unfavorable influences.

Infectious diseases sometimes lead to thyroiditis, and thus to Graves's disease. Tuberculosis and rheumatism are prominent factors in this connection.

Acute articular rheumatism occupies an important place among the infectious diseases which lead to the development of exophthalmic goiter. The case is reported of a man of 30 in whom an acute rheumatic attack was followed by the development of Graves's disease, with goiter, exophthalmos, tachycardia, polyuria, and paroxysmal sweating as symptoms. The fact that the patient and his parents were alcoholics is not sufficient to explain the production of this syndrome. It is probable that an accentuation or other disturbance of the thyroid function, by reacting on the nervous system—on the medulla, in particular—may lead to the

development of Graves's disease. Souques (*Bull. méd.*, Jan. 26, 1910).

The writer observed Graves's disease in 27 of 337 patients with pulmonary tuberculosis during 1908, and in 28 in 1909. The Graves symptoms must often be overlooked in such cases or else be ascribed to the tuberculous infection. The connection between the Basedow symptoms and the tuberculosis is more than casual, as is shown by the benefit that follows treatment addressed to the exophthalmic syndrome. As this improves, the pulmonary symptoms subside and the patient may be clinically cured. F. Bialokur (*Zeit. f. Tuberkulose*, Bd. xvi, S. 567, 1910).

The possibility of syphilis acting as a pathogenic agent in some cases has recently been suggested.

The writer examined blood from several cases of exophthalmic goiter, and a spirocheta was found, having in all the cases the same apparent characteristics. Further examination, with somewhat improved technique, showed, however, that this organism is extremely common in human blood, and that it occurs in almost every specimen examined, from both ill and healthy persons. Up to the present time the blood from 12 cases of exophthalmic goiter, from 20 patients suffering from other diseases, and from 15 healthy people has been examined, a total of 47 cases, and the organism has been detected in all except 3. It has been found in children as well as in adults. The organism is actively motile and is very variable both in length and thickness. The majority measure from 4 to 30 microns in length; very long forms are, however, met with. Some are extremely thin, like the *Treponema pallidum*: others are almost as thick as typhoid bacilli. Chambers (*Lancet*, June 21, 1913).

Uterine fibroids, disease of the nasal tract, and disease of the intestinal tract—the latter serving perhaps as a

source of ptomaine poisoning—are occasionally partial causes which should be remembered during efforts at treatment.

The relief of a pelvic lesion is in certain cases followed by the amelioration of the exophthalmic goiter. It seems highly probable that in certain instances the pelvic lesion stands in a causal relationship to the exophthalmic goiter. The possibility that reflex irritation may exert an influence in producing an increased or perverted secretion of the thyroid makes it desirable that, when the diagnosis of exophthalmic goiter is made, search should be made for some possible source of irritation. Hertzler (*Jour. Amer. Med. Assoc.*, Dec. 23, 1911).

The writer calls attention to the very large proportion of uterine growths associated with goiter, typical and atypical: 15 per cent. of all the cases of goiter seen (186), included in 5370 cases of internal disease, proved to be associated with uterine myoma or fibromyoma. H. L. Elsner (*Med. Record*, May 3, 1913).

PATHOLOGY.—Histological examination of a large number of diseased glands removed by the Mayos showed that there is a definite increase of the parenchyma of the organ in all forms of Graves's disease, with evidence of secretory overactivity of the cells. This is shown by an increase of cells in the alveoli, by increase in the number of alveoli, and also by papillomatous invagination into the vessels of the gland. These changes may affect the entire organ or only certain areas. Overactivity of the gland does not mean, however, that its secretion is normal in character.

We still lack the knowledge as to whether the stimulus is from within or without, as a chemical irritant or hormone. The gland elaborates iodine, of which there is less in the gland of hyperthyroidism than in

the normal gland; but Reid Hunt has shown that in such cases there is more iodine in the blood, it being produced, delivered, and slowly excreted from the system, contrary to its usual rapid elimination. It is also shown by Marine and others that colloid goiter contains more iodine in the whole gland than in the normal thyroid, but bulk for bulk the colloid goiter contains less iodine than normal thyroid. C. H. Mayo (*Surg., Gynec., and Obstet.*, Aug., 1910).

The writer injected dogs with the juice squeezed from goiter taken from patients with the exophthalmic form. The animals developed constantly a transient syndrome with the blood-findings of exophthalmic goiter, and exophthalmos in some instances. This seems to demonstrate that exophthalmic goiter is not due to excessive but to perverted thyroid functioning. The thyroid seems to be unable to collect and store the iodine in its normal form of iodothyryn, but only in the form which might be called the Basedow form. Klose (*Archiv f. klin. Chir.*, Bd. xcv, No. 3, 1911).

A study of the thyroids of 69 cases observed by the writers showed that the anatomical changes in the several body tissues in exophthalmic goiter are variable and manifold. The most prominent and most constant change is active hyperplasia of the thyroid and lymphoid tissues. These changes are not constant, since the exophthalmic goiter syndrome, as at present recognized, may co-exist with a normal thyroid, with a colloid goiter, with an actively hyperplastic thyroid, with an atrophic thyroid, or with a tumor of the thyroid. The great majority of individuals presenting this syndrome in recognizable form have some degree of thyroid and lymphoid hyperplasia, and all true cases have had, during the developmental stage, active thyroid and lymphoid hyperplasia. Active thyroid and lymphoid hyperplasia are not specific for this

syndrome, since similar anatomical changes are present in a variety of other abnormal body states. D. Marine and C. H. Lenhart (*Archives of Internal Med.*, Sept. 15, 1911).

By injecting ground human goiter material (avoiding the exophthalmic type) into the peritoneal cavity of dogs, rabbits, and rats, the writer induced a syndrome in many instances closely resembling human exophthalmic goiter. Ground material proved more successful than the extract of the goitrous thyroid. Baruch (*Zentralbl. f. Chir.*, March 9, 1912).

As yet neither specific nor constant anatomical changes in the thyroid of exophthalmic goiter have been demonstrated, although out of 137 specimens examined by the author about three-fifths showed some degree of hyperplasia. It is believed that the proportion of glands showing active hyperplasia at the time of operation is greater in a series of exophthalmic goiters than in ordinary goiter.

As far as is at present known, the iodine content, the storage of iodine in the gland, and the involution of active hyperplasia by the use of iodine are identical with those iodine relations common to other clinical associations.

The thyroid of exophthalmic goiter has no different pharmacological action on animals or therapeutic action on myxedema or toxic action on patients with exophthalmic goiter than thyroid preparations from other clinical associations with like iodine contents. David Marine (*Ohio State Med. Jour.*, July, 1912).

The writer observed the following morbid changes in Basedow's disease: (1) Retrogressive changes and destruction of the specific elements of the ovaries; (2) marked hyperemia; (3) marked increase of connective tissue; (4) formation of cysts. The uterus and mammary glands undergo atrophy of the specific elements, which are replaced by fibrous connective tissue. There is also

hyperplasia of the lymphatic system, the spleen, and the lymphatic glands. In the adrenals there is lessening of the cortical layer and hyperemia. The medulla is hyperemic and filled with eosinophilic granules. The heart, liver, and kidneys show evidence of marked parenchymatous degeneration. The alimentary canal is in a condition of follicular catarrh. A. N. Chrustaleff (*Roussky Vrach*, Jan. 5, 1913).

As to the relation between the changes in the thyroid and the symptoms, L. B. Wilson found, in a research based on 1208 glands, that, very early, acute cases show pathologically hyperemia and cellular hyperplasia in more or less of the gland, if the more enlarged lobe has been removed. Later, acute cases show greater parenchyma increase and increased absorbable secretion. The increase in parenchyma is in proportion to the severity of the symptoms. Cases in which there is remission of toxic symptoms show evidence of decreased function, or of probably decreased absorption. Patients who have recovered from the toxic symptoms, but still suffer from heart or nerve lesions, or from myxedema, show exfoliated epithelium and thick, non-absorbable colloid. The mild cases, of long duration, show increase of parenchyma by the multiplication of alveoli, but no increase of functional power of the individual parenchyma cells. Simple goiters should be regarded as multiple retention cysts, filled with non-absorbable secretion, cell detritus, etc.

The hypersecretion of the thyroid is dependent on the chemicohistological behavior of the gland before clinical manifestations develop. A diffuse colloidal degeneration may exist without the knowledge of either patient or physician. More iodine is absorbed from the Basedow gland than under other conditions,

while this surplus iodine is not eliminated as it is normally from the system and at once. Kocher (Archiv f. klin. Chir., Bd. xcii, Nu. 2, 1910).

An examination of the thyroid glands removed from 1208 patients in the Mayo clinic presenting symptoms which would ordinarily be diagnosticated as exophthalmic goiter and, for purposes of control, 585 thyroids removed during 1912 from patients whose condition would ordinarily be diagnosticated as simple goiter, led to the following conclusions: 1. A detailed pathological study of fixed tissue preparations of the thyroids removed from adults, and the finding thereby of marked primary parenchymatous hypertrophy and hyperplasia, permit the pathologist to diagnosticate exophthalmic goiter with about 95 per cent. of accuracy. At the same time, a consideration of the data observed during the examinations will permit him to estimate the stage of the disease in about 80 per cent. of the cases and the severity of the disease in about 75 per cent. of the cases. 2. A similar study of thyroids from adult patients, and the finding thereby of no marked hypertrophy, hyperplasia, or regeneration of parenchyma, will permit the pathologist to diagnosticate non-toxic goiter with about 75 per cent. of accuracy. 3. The most difficult cases to diagnosticate pathologically are those of the clinical toxic non-exophthalmic type.

Our knowledge of these cases is still too incomplete to permit of conclusions concerning the details of their pathology. L. B. Wilson (Medical Record, Aug. 30, 1913).

Special toxicity has been attributed to *adenomata* of the thyroid, which as a rule grow very slowly and, though occasionally present in adolescent goiters, are usually discovered after the thirtieth year.

It is now (1921) generally believed that all adenomata ultimately become

toxic, the degree of toxicity at first being so slight as hardly to be perceived.

Basal metabolism tests show, however, that the rate of metabolism is raised long before toxic symptoms are observed, thus indicating that the latter are advanced manifestations of the thyroïdal disorder.

An enlarged persistent thymus has been found in numerous cases. While it may occur coincidently with the Graves syndrome or be a result of the general hyperplasia it provokes, the enlarged persistent thymus has been found greatly to compromise the issue when surgical measures are resorted to.

The writer does not regard hypertrophy of the thymus as a special danger in exophthalmic goiter.

The thymus is frequently unduly large in all forms of the latter disease, but this is not a constant occurrence.

When it is associated with hypoplasia of the adrenals, the resulting instability of the cardiovascular system may be a dangerous feature of the clinical picture. C. Lenormant (Jour. de chir., Sept., 1912).

An analysis of 10 cases of exophthalmic goiter in which the patients died during or soon after an operation on the thyroid; the thymus was found unusually large. Study of 133 similar cases in literature showed that 76.5 per cent. of all the exophthalmic goiter patients who have died during or immediately after an operation on the thyroid had an unusually large thymus. It seems evident, he thinks, that the thymus and the thyroid act in concert and each aggravates the morbid condition induced by abnormal functioning of the other. Certain features of the case suggest, further, that adrenal functioning is depressed by excessive or perverted thymus functioning. In all the 10 cases reported the adrenals were exceptionally small. Matti

(Deut. Zeit. f. Chir., Bd. cxvi, Kocher Fest., 1912).

Considerable personal experience and 151 papers in the literature suggested that an unduly large thymus accompanies established exophthalmic goiter in fully 80 or 90 per cent. of the cases. There is nothing to show that the large thymus has any special toxic action, but it suggests that the status thymicolymphaticus represents a special reaction of the tissues to excessive functioning of the thyroid. He regards the so-called "thymus death" as a pure "heart death." The patient who has long suffered from the toxic action of a diseased thyroid, seriously injuring the heart, is liable to die at any moment from failure of the latter. Melchior (Centralbl. f. d. Grenzgeb. d. Med. u. Chir., Bd. xv, Nu. 3, 1912).

The lymph-glands throughout the body may also be enlarged.

Case of exophthalmic goiter with pseudoleukemia. The pseudoleukemic stage may be the result of the general condition of intoxication in Basedow's disease. In his case death took place under evidences of hyperthyroidism after a partial strumectomy. An evidence of the severity of the autointoxication is that the patient's urine taken before the operation and injected into a guinea-pig produced no symptoms, but the same quantity taken during the period of hyperthyroidism and injected into another guinea-pig produced death in a comparatively short time. Another noteworthy feature was a high percentage of iodine in the thyroid gland. Caro (Berl. klin. Woch., April 29, 1907).

The blood picture is suggestive: while the number of red blood-corpuscles is approximately the same, the leucocytes are reduced, almost always, according to Kocher, at the expense of the neutrophile polynuclears, while, on the other hand, the lymphocytes are relatively or absolutely increased to a marked degree.

Examination of 6 patients with typical and 7 with pseudo-exophthalmic goiter showed lymphocytosis and the preponderance of mononuclears as special characteristics. There was no essential injury of the bone-marrow, but an abnormal reaction on the part of the lymphatic apparatus,—a fact confirmed by the frequent enlargement of the spleen and of the lymph-glands. J. Gordon and N. v. Jagic (Wiener klin. Woch., Nov. 12, 1908).

Blood examination of 20 positive cases of exophthalmic goiter and a large number of the so-called "formes frustes" or abortive types showed the almost constant presence of a relative lymphocytosis, both in genuine Graves's disease and in pseudo-exophthalmic goiter. In doubtful cases the examination of the blood may help toward the recognition of the thyrotoxic basis of the trouble, as indicated by a relative increase of the lymphocytosis. Thus, the presence of lymphocytosis in a given case acquires considerable importance for the differential diagnosis. Meanwhile the absence of lymphocytosis in a suspected case of exophthalmic goiter or thyroid intoxication does not suffice for the exclusion of such a diagnosis. Buehler (Munch. med. Woch., May 10, 1910).

The white blood picture shows a constant lymphocytosis. Other phenomena sometimes alleged, as leucopenia, eosinophilia, and mononucleosis, are not characteristic. The lymphocytosis is not dependent on the thyroid, but the thymus. In all well-developed cases the thymus is involved. Graves's disease is also a dysthymism. Lampe (Deut. med. Woch., June 6 and 13, 1912).

Other forms of goiter occur in Graves's disease, but they arise from other causes, such, for example, as those which lead to the endemic variety. But the changes found in them are not characteristic of the exophthalmic form of goiter.

There are slight histological differences in different cases, such that sometimes the arrangement of the cells is diffuse, while in other cases small, ill-defined follicles are formed, and in others the tissue takes on an embryonic character. Again, the epithelium may be of slender form and the arrangement glandular.

A relatively great number of special lesions have been found in one or another segment of the nervous system, especially the medulla oblongata, but they are, in all probability, secondary and indicative of the excitation going on there.

The heart may be found dilated and its muscles degenerated; and so, also, degenerations in the arteries and in the internal organs have been found; and in the spinal cord.

A condition of heart to which the name of "Kropfherz" (goiter heart) was given years ago by Continental surgeons is, in its severe and later stages, a serious cause of anxiety to the operating surgeon. The cause of the condition is uncertain, but may be due to long-continued mechanical pressure upon the trachea and veins at the root of the neck. There is another kind of goiter heart in which the rapidity and irregularity of the heart are probably due to chronic poisoning by thyroid secretion. Such is the heart of Graves's disease. J. Berry (*Lancet*, March 1, 1913).

The time has gone by when any considerable number of supporters can be found for the theory that this disease is due to the localized lesions occasionally found in the medulla oblongata or the sympathetic system.

The key to the real mystery of the disease must be sought elsewhere, and it appears to me that the only plausible explanations of the great array of symptoms which are liable to present

themselves are, on the one hand, that suggested by the name "neurosis," and, on the other hand, that which assumes a toxic action due to altered secretion of the thyroid gland.

Exophthalmic goiter is the result of both a thyroid and a nervous factor. The thyroid secretion acts on both the sympathetic and the cerebrospinal nerve systems. Increased secretion in the thyroid has no clinically appreciable injurious influence on the two nerve systems when they are sound. But when one or the other of the two great nerve systems is irritable or diseased, then the products of excessive thyroid functioning irritate the irritable nerve system; if this happens to be the sympathetic-nerve system, then this in turn stimulates the thyroid and heart to extra functioning. Oswald (*Correspondenzbl. f. Schweizer Aerzte*, Oct. 20, 1912).

It has been proved experimentally that the most trifling mechanical injuries of the gland are enough to change the character of the secretion and induce parenchymatous hypertrophy, and it is far from unreasonable to suppose that the same result might follow an alteration of the secretion due to nervous influence. In favor of the "neurotic" theory is, of course, the strongly marked clinical relationship of the disease and its mode of origin. On the other hand, there is also a great deal to say in favor of the view that the altered and increased secretions of the thyroid gland are important factors. The therapeutic and experimental study of thyroidization is in support of this view, and the striking contrast between myxedema and Graves's disease, as regards the condition of the skin, the nervous system, and the like, even though it does not fully bear

critical analysis, is, in general, in favor of this conception.

Histological study of the superior cervical sympathetic ganglia removed at operation from 16 cases of hyperplastic toxic goiter revealed definite histologic changes in the cells, namely (1) hyperchromatization, (2) hyperpigmentation, (3) chromatolysis, and (4) atrophy or (5) granular degeneration of the nerve-cells. Accompanying the more advanced changes in the ganglion cells were similar degenerative changes in the nerve-fibers and an increase of connective tissue throughout the ganglion, but especially in the outer and middle coats of the vessels and in the periganglionic tissue. The pathologic changes were parallel to the stage and intensity of the symptoms of hyperthyroidism and to the hyperplastic and regressive changes in the thyroid. L. B. Wilson (*Amer. Jour. Med. Sci.*, clii, 799, 1916).

The writers made studies of the basal metabolism of a large number of cases of exophthalmic goiter in various stages of intoxication. They found that the basal metabolism provided a very accurate measure of the degree of toxicity in these cases, being on the average within the normal limits of variation in the non-toxic cases, 43 per cent. above normal in the mildly, 53 per cent. above in the moderately, and 76 per cent. above in the severely toxic cases. It also gave a close measure of the response to therapeutic measures and it was found that rest in bed produced a marked fall in the metabolism and an improvement in the other signs of toxicity, and that the addition of sedatives or of quinine hydrobromide to the rest treatment did not hasten or increase the fall in metabolism. Intensive X-ray treatment produced a similar marked fall in metabolism in a number of cases, while in others it was without effect. Surgical measures usually produced an immediate marked decrease in toxicity, but there was a definite tendency toward

recurrence. The authors believe that the treatment of these cases should be by complete rest and intensive irradiation until the metabolism has reached a level; that if they fail to reduce the metabolism to within 20 per cent. of the normal resort should be had to surgery; and that further active treatment should be undertaken if there is a rise in metabolism after surgical treatment. The presence of a rising metabolism in spite of rest and irradiation seems to contraindicate surgical intervention. Means and Aub (*Jour. Amer. Med. Assoc.*, July 7, 1917).

Thyrototoxic cardiopathy is identical with idiopathic dilatation and hypertrophy of the heart. There is great increase in the size of the heart, with or without murmurs of relative insufficiency and with or without signs of decompensation, as shown by dyspnea, subcutaneous edema, transudation in the serous cavities, cyanosis and the like, by tachycardia, and, on occasions, by bilateral exophthalmos with or without detectable indications of enlargement of the thyroid. There is great enlargement of the heart, due to dilatation and hypertrophy of all the chambers or of different combinations of chambers without valvular or pericardial, arterial, renal, pulmonary or other of the causes customarily invoked. Symmers (*Arch. of Internal Med.*, Mar., 1918).

The pathology of goiter appears in many cases to be secondary to infection or to some profound disturbance of the nervous system which calls for increased thyroid output; this in turn produces changes in the sympathetic nervous system, adrenals, and other organs of the body. The combined effect makes up the picture of exophthalmic goiter, with varying degrees of hyperthyroidism. Pember and Nuzum (*Wisc. Med. Jour.*, xvi, 392, 1918).

PROGNOSIS.—Some cases of Graves's disease run a rapid course, ending in recovery, and this is especially true of outbreaks occurring in

childhood. In a case under the observation of a colleague of the writer, a girl 8 years old had an acute attack due to fright from harsh treatment by her father, but was well at the end of a few weeks. Recovery is also possible in acute cases occurring in adult life and in mild chronic cases, though it is far more common to see some few symptoms persist in spite of substantial recovery from the rest. The exophthalmos often overlasts the other signs.

Some cases have a malignant aspect almost from the outset, and die very rapidly after a few weeks or even days, or from exhaustion and cachexia at the end of a few years. Even cases of great severity may, however, take a favorable turn and substantially recover under favorable conditions; so that no case ought really to be despaired of.

Study of 51 cases in which the history of the patients had been followed fifteen years. The treatment had been exclusively medical with two exceptions. The ultimate outcome was 19.6 per cent. improved and 33.3 cured *i.e.*, favorable in 52.9 per cent. The experiences of others with non-operative treatment all confirmed his own experience that over half of the patients with exophthalmic goiter can be permanently improved and one-third completely cured or at most left with a little exophthalmos. Syllaba (Therap. der Gegenwart, Nov., 1910).

TREATMENT.—A great number of methods have been used for Graves's disease and have had their enthusiastic supporters, but on the whole the conscientious physician should have two aims in view: first, to treat his patients with persistence and determined confidence, in order that they may catch his tone of

encouragement; next, that each case should be energetically treated at the most assailable point or points.

The profession at large labors under a misapprehension concerning the relative merits of surgery and medical treatment in this disease. The average physician deems the low mortality of surgeons such as Kocher or the Mayos, which is practically *nil*, the indication upon which his decision concerning his patient is to be based. The truth of the matter is that this low mortality represents the *operative* death rate which in no way conveys a correct idea of the actual facts in the case. The only true results are afforded by the subsequent histories of the operated cases. Not only does this show that even the Mayos do not obtain a proportion of cures of more than 45 per cent. as shown by Judd and Pemberton of the Mayo Clinic (Surg., Gynec. and Obstet., Mar., 1916) eight years after operation, but when we consider the results of the average surgeon, the operative mortality rises to 5 per cent. and in some instances higher, while the ultimate results hardly reach 30 per cent. cures.

The medical treatment on the other hand does not, of course, entail operative deaths. Leaving out of all consideration the work of highly trained endocrinologists, the demonstrable cures of the *average* practitioner not only exceed 30 per cent. but the operative mortality of the surgeon being omitted, his permanent cures surpass those of the average surgeon. And the general practitioner attains these results in spite of that product of ignorance, the "symptomatic" treatment of exophthalmic goiter generally resorted to, which compromises the chances of the patient's recovery by leaving unassailed the primary cause of the disease.

Many patients are subjected to arterial ligation and thyroidectomy entailing risks and morbid after-effects, who could be cured by medical treatment, did the latter aim to remove the primary cause of the disease and its morbid effects. EDITORS.

Leading authorities on the subject now insist as first step, on thorough removal of the primary disorder, *i.e.*,

that which produces the toxin or poison to which the excessive activity of the thyroid is due. Whether the toxemia be in imbedded tonsils, peridental or dental abscesses, pyogenic disorders of the nose, pharynx or sinuses, a chronic gastro-intestinal, hepatic or gall bladder disorder, fecal impaction, chronic constipation, appendicitis, cystitis or any condition which continuously contributes some toxic substance to the blood, should be thoroughly eradicated, if a cure is to be expected. In some instances gonorrheal infection, syphilis or tuberculosis may act as the underlying cause. Adequate treatment of the causative disease will then cause the thyroid disorder likewise to disappear.

Case of exophthalmic goiter is described in which unmistakable signs of apical tuberculosis disclosed its toxic origin: the tuberculosis toxins. Under specific treatment of the tuberculosis, the apex cleared up and with this all the thyroid symptoms disappeared. In some cases of pure exophthalmic goiter, the writer has witnessed a spasmodic cough suggesting tuberculosis of purely vagotonic origin as also in some cases of simple poisoning from thyroïdin. De Santa Maria (Siglo Medico, May 4, 1918).

Every case should be examined for focal infection. Mild or incipient cases are cured by prolonged rest, hygienic and medical means; 50 per cent. of the more advanced cases are curable by the same methods. If a case has been under medical care for some time without improvement it should be placed in the hands of an experienced surgeon, skilled in thyroid work. Cases showing myocardial insufficiency or serious arrhythmias, as alternation, fibrillation, or flutter, should be treated medically. X-ray pictures of the chest should be taken to discover extraneously placed accessory or dipped thyroids and to determine the size of the thymus gland. The ideal treatment is en-

forced therapeutic rest. Gordinier (Dominion Med. Mthly., Oct., 1918).

Thoroughness is also imperative in the correction of any condition entailing fecal stases. The actual condition present should be ascertained by a barium meal X-ray examination. If present **high enemas**, the patient lying on the right side to enable the fluid to reach the cecum, should be used. Half way measures are futile because the gland continues to secrete abnormally as long as the slightest toxemia lasts.

Quite equal in importance to removal of the source of the toxemia is **absolute rest** in order to reduce to a minimum the production of tissue wastes, which also excite the thyroid gland to excessive activity. The rest must be mental as well as physical, the waste products of nervous catabolism, according to Sajous, exciting the thyroid like those from any other source.

These two factors once provided for, the next step is to reduce markedly the activity of the thyroid gland by causing constriction of its arteries.

The most satisfactory pharmaceutical remedy to antagonize this hyperthyroidism seems to be, as recommended by Forchheimer, the **neutral hydrobromide of quinine** given in 5-grain (0.3 Gm.) capsules three or four times daily, increased until the limit of endurance is reached. This is continued until the subjective symptoms have disappeared, the drug being then reduced tentatively until one capsule is taken daily, or even one every other day, cautioning the patient to resume the former dosage at once if any symptoms reappear. It is greatly aided by the addition of **ergotin**, 1 grain (0.06 Gm.) per dose of quinine.

Occasionally a patient cannot take more than 1 or 2 **quinine** capsules

a day. At the beginning of treatment patients are told that no marked effects may be seen short of a month, and they must be prepared to continue it for at least two years. Great stress is laid upon this because patients become very easily discouraged if no immediate results are obtained. It should be continued until all the symptoms have disappeared, which may be in four months or as long as three years. The order of disappearance of the symptoms seems to be, first, the tachycardia subsides, then the thyroid gland diminishes, and finally the exophthalmos and tremor, the last two only after a prolonged course of treatment. They have never seen any bad permanent effects follow from the administration of the quinine, and the only unpleasant effect is occasional tinnitus, especially if large doses be given. It is advisable to continue the drug in small doses, 1 capsule three times a week during the second year, and the patients are cautioned to immediately return to former doses at the first indication of any reappearance of their old symptoms. Jackson and Mead (*Homeo. Eye, Ear, and Throat Jour.*, Nov., 1908).

The writer administers **quinine sulphate** in doses of 15 or $22\frac{1}{2}$ grains (1 or 1.50 Gm.) at the evening meal, divided into 3 capsules, taken at fifteen-minute intervals; he keeps this up for twenty days each month, with suspension for ten days. He generally commences with $7\frac{1}{2}$ grains (0.50 Gm.) and sometimes supplements the action of the quinine with another powerful vasoconstrictor—ergot—giving from $1\frac{1}{2}$ to $7\frac{1}{2}$ grains (0.10 to 0.50 Gm.) daily, in the morning.

One of his patients took from 15 to $22\frac{1}{2}$ grains (1 to 1.50 Gm.) of quinine every day for six months with scarcely any intermission, and can now be regarded as clinically cured. Cure was the rule in all his cases. Kelsch (*Bull. de l'Acad. de Méd.*, Feb. 25, 1908).

The following treatment gave the writer good results: For two weeks **quinine sulphate** is given in large doses (1.5 to 2 Gm.— $22\frac{1}{2}$ to 30 grains—daily), the drug being pushed to the utmost limit short of producing tinnitus. This is followed by one week's treatment with **sodium salicylate**, 2 to 4 Gm. (30 to 60 grains) daily, then by two weeks of **calcium chloride**, 3 to 4 Gm. (45 to 60 grains) daily, an interval of eight days being allowed after each medication. A **salt-free diet** should be enjoined, salt hindering the curative action of calcium chloride. J. A. Sicard (*Prescriber*, April, 1911).

To counteract the toxemia good results have been claimed for the use of a **serum** originated by Rogers and Beebe. It is prepared by injecting two proteids—a nucleoproteid and a thyroglobulin—into rabbits.

Another useful agent is a **serum** obtained from **thyroidless goats**. This goat serum is thought to contain a substance (antithyroidin) in excess, which counteracts the poisonous action of excessive thyroid secretion in the patient. In summarizing the results obtained in the last six years, in over 2000 cases treated, Beebe stated that in a patient who was not already moribund results might be expected to this degree: 50 per cent. of these patients were made so well that they did everything they wished to do. Many of them still had a somewhat enlarged gland. Their heart and nervous and other symptoms disappeared. About 30 per cent. more were made comfortable, so that their condition in life was very satisfactory. In about 20 per cent. they failed to get satisfactory results.

Results obtained in 16 cases treated by serum: 5, or 31 per cent., have been cured, the oldest patient having been without symptoms for over

three years, the last for about six months. One of these cases was very severe, her pulse being over 180 on exertion, and with a great deal of nausea and diarrhea; within six weeks she was practically relieved of all subjective symptoms, her pulse being reduced to about 80; 7, or 44 per cent., were markedly improved so that their life had been rendered much more comfortable, and this improvement apparently is permanent; 2 of these patients were very ill, and 3 of them have taken the serum treatment twice, with an additional improvement the second time; 4, or 25 per cent., do not appear to have made any permanent improvements, though all of these were certainly better while under the direct charge of the authors, but relapsed more or less promptly after being sent home. Only one patient treated has died. McCaw Tompkins (*Old Dominion Jour. of Med. and Surg.*, Oct., 1909).

Various agents having the same object in view are available on the market. One of these is a German product termed **antithyroidin**, which is available in bottles containing $2\frac{1}{2}$ drams (10 c.c.) with sufficient carbolic acid to preserve the fluid. This remedy prepared after Möbius's directions has been praised by various writers. It may be given in doses ranging from 10 minims (0.65 Gm. to 30 minims (2 Gm.) twice daily, increased if necessary. The drug has no cumulative action.

In all of the authors' cases blood-pressure study proved the disease to be one in which, despite the small and thready pulse, the sphygmomanometer showed high pressure. With an improvement in the tone and character of the pulse under treatment the measure of the blood-pressure showed no appreciable reduction. They are positive that **antithyroidin** is a remedy which can be used for the relief of the annoy-

ing and alarming symptoms of exophthalmic goiter in typical and atypical cases. The greatest improvement is found in the relief of the tachycardia, precordial distress, and tremor. This improvement is hastened by rest in bed and close attention to diet. Rest in bed and diet alone, without the administration of antithyroidin, will not lead to the same degree of cardiac comfort. Improvement of one or more of the symptoms of the disease is likely to follow within from three to seven days after beginning the use of the remedy. If there is no improvement of symptoms after from three to four weeks of administration, the chances are against ultimate benefit from the prolonged use of the serum. In serious cases it will be necessary to continue the treatment during many months. In all cases after the disappearance of the subjective symptoms, it will be wise to administer antithyroidin during periods varying from four to eight weeks at intervals of two or three months. Cases without marked goiter, with slight exophthalmos, tremor, and the Graefe symptom have yielded most readily to the antithyroidin treatment. The enlarged thyroid has become perceptibly smaller, but has not returned to the normal size. Exophthalmos continues to be the most rebellious symptom, never yielding entirely to antithyroidin treatment. Nervous symptoms usually yield as the heart becomes slower. The many fears which take possession of these patients are also relieved at the same time. The majority of their patients increased in weight. Patients who have taken antithyroidin during a long period feel, when the serum is discontinued, as if they had been robbed of a food to which they are entitled, and return to its use with confidence and pleasure. In no case have the authors had occasion to regret the trial of antithyroidin. It has always proved itself harmless. It may be given during pregnancy

without fear of injuring the mother or fetus. Hypertrophied and dilated hearts offer no contraindication to its administration. H. L. Elsner and J. R. Wiseman (N. Y. State Jour. of Med., June, 1906).

Thyroidectin is another product having the same pharmacological end in view. It consists of a reddish-brown powder precipitated from the blood of thyroidectomized sheep. It is given in capsules, 5 to 10 grains (0.3 to 0.65 Gm.) three times daily.

In 5 personal cases treated with thyroidectin, none gave results greater than the ordinary variation in symptoms in exophthalmic goiter under the influence of rest, suggestion, and regulation of habits, while in one case the remedy appeared to aggravate the symptoms. His 2 patients treated with desiccated milk of thyroidectomized animals showed extreme aggravation of symptoms in one case, apparently a direct result of the treatment, and in the other improvement, probably due to restriction of coffee. The results of treatment with thyroidectin seem far inferior to those secured by rest, symptomatic medical treatment, or partial thyroidectomy. Dayton (Jour. Amer. Med. Assoc., April 22, 1911).

Rodagen is a German preparation obtained by precipitation from the milk of thyroidectomized goats. The milk itself of such animals has also been recommended.

Case in which the use of **milk from a normal goat** produced a cure of the disease, all antibodies and similar theories to the contrary notwithstanding. Clement (Bull. méd., No. 8, 1909).

The treatment of exophthalmic goiter with the milk from thyroidless goats or preparations made from it must depend in a considerable degree on the dosage. Clearly a sufficient dose must be given. One of the preparations (**rodagen**) is said to be

made by mixing the dried milk with an equal quantity of sugar of milk, which is added as a preservative; 1 ounce (30 Gm.) of dried milk would correspond with about 4 ounces (120 c.c.) of the whole milk. If, then, 1-dram (4 Gm.) doses of the mixed powder were given, each dose would correspond to 2 drams (8 c.c.) of fresh milk; and if the doses were ordered three times a day, they would correspond to 6 drams (24 c.c.) or possibly 1 ounce (30 c.c.) of the milk a day, hardly one-thirty-second of the quantity of **goat-milk** necessary in some cases. Edmunds (Lancet, Dec. 9, 1911).

Arsenic, which has been shown to antagonize the activity of the thyroid gland physiologically, has been used with some degree of success. Its best effects are obtained when given with the **bromides**. The following formula has recently (1913) been recommended by Moon:—

R *Liquoris potassii arsenitis* ℥iij (0.2 Gm.).
Sodii bromidi gr. x (0.6 Gm.).
Aquæ q. s. ad 5j (30 Gm.).

M. Sig.: To be taken three times daily.

Sometimes arsenic is not well borne when the stomach is irritable; subcutaneous injections of the **cacodylates** may then prove useful.

The writer recommends the intravenous injection of a solution of atoxyl and sodium iodide, the advice being based on the affinities of the two drugs for the organs affected, notably the thyroid gland. He injects at frequent intervals 2 c.c. (32 minims) of the following solution:—

R *Atoxyl* gr. xv (1 Gm.).
Sodii iodidi 3j (4 Gm.).
Aquæ destillatæ . 3v (20 c.c.).

M. Fiat solutio.

Under this treatment the trembling ceases and the profuse sweating is abated. The diarrhea, hypertrophy of the gland, and tachycardia also

disappear. Mendel (Therap. der Gegenwart, Feb. 2, 1910).

If we realize the disease to be essentially due to an excessive or morbid secretion of the thyroid gland, which gives rise to various circulatory disturbances and a condition of nervous erethism, we shall be in a position both to diagnosticate and treat the minor manifestations before either exophthalmos or an appreciable enlargement of the thyroid has developed. Moon (Practitioner, Oct., 1912).

Sodium salicylate has recently been taken up by Babinski. He advises its use particularly in cases where the disturbance is of infectious origin, *e.g.*, after acute rheumatism. The patients to whom the salicylate was administered showed a rapid diminution of the characteristic symptoms and the size of the thyroid, as well as a general constitutional improvement. The drug is prescribed thus:

R *Sodii salicylatis* .. gr. xij (0.75 Gm.).
Sodii bicarbonatis. gr. iv (0.25 Gm.).

Ft. in cachetam no. j.

Sig.: Four cachets a day, to be taken with the meals.

The salicylate treatment should be continued a month, intermitted, then resumed.

The writer had 3 cases in which the administration of $\frac{1}{60}$ grain (0.001 Gm.) of **arsenic** combined with the same amount in tablet form of **mercury perchloride**, taken three times a day, caused signs of improvement to appear about a month after beginning the remedies. In 1 case the patient continued them with little interruption for nearly three years, when complete recovery—now of two years' standing—ensued. Weber (Med. Record, Feb. 8, 1908).

As previously stated the best results are attained in the treatment of Graves's disease when a toxemia, due to any one or more of many endogenous or ex-

ogenous factors, is regarded as the cause of cases that are not clearly due to violent emotions, shock, and kindred agencies. Sajous urges that, inasmuch as any case of goiter may become one of Graves's disease, the appearance of any enlargement of the thyroid not ascribable to an ephemeral cause, pregnancy, an acute febrile process, etc., should at once be placed under a treatment having for its purpose the elimination of the toxemia and its cause. Intestinal antiseptics, **thymol** and **menthol** especially, along with **sodium phosphate** to keep the intestines free, are recommended by him, in addition to **quinine hydrobromide**.

Intestinal antiseptics appear to be useful auxiliaries to treatment. Whether or not the disorder is originated by the absorption of toxic products from the intestine, it is certainly aggravated thereby. **Dieting** does much to diminish this liability. In addition, however, it is well to **wash out the colon thoroughly with hot saline solution** once or twice weekly, and to administer such agents as the **salicylic compounds**, **betanaphthol**, **benzonaphthol**, **hexamethylenamine**, **guaiacol carbonate**, and the like, singly or in association, from time to time. Also an occasional course of **calomel**, followed by a **saline aperient**, or the occasional use of **castor oil**, and the **cholagogue purgatives**, helps.

Menthol has been urged as a specific. Whether it acts as an intestinal antiseptic or otherwise, some cases are greatly benefited by it. The writer was first led to its use by the history of an intelligent patient presenting other symptoms of vascular disorder, but in whom he could not find enlargement of the thyroid gland or exophthalmos. Observing him search for these signs, the man informed the writer that he had had exophthalmic goiter some ten years previously, but had recovered while

taking menthol. That may have been a coincidence, of course; but at all events the drug is useful in some cases, and it may be tried when other means have proved inefficacious, or as a succedaneum to the organ preparations during the periods of intermission. S. Solis-Cohen (Amer. Jour. Med. Sci., July, 1912).

Writer reports 3 cases in which chronic colitis of many years' standing preceded the symptoms. All were relieved by treatment of the bowel disease, after failure of other measures usually employed, including in 1 case partial thyroidectomy. He found nothing so good in these colonic cases as **lavage of the intestine with 1 per cent. solutions of ichthyol**. As much as 1 liter (quart) can be used in persons having a large colon, and half as much in others. **Bacillus bulgaricus** in liquid cultures reduces the tremor as well as the headaches and insomnia. Hemmeter (Jour. Amer. Med. Assoc., Dec. 13, 1913).

Diarrhea, sometimes stubborn, is best treated by large **oil injections**, which will remove all the impacted masses. In 4 fully developed cases of Basedow's disease recorded by Epstein, an absolute cure was established by this simple treatment, and 1 case was observed fifteen years without recurrence. Thomson banishes all meats from the **diet** to prevent autointoxication.

Ninety per cent. of the writer's cases have been either benefited or cured by medical treatment. The writer finds indicanuria and other evidences of intestinal stasis in a majority of his cases, and gives **podophyllin** capsules or other purgatives regularly as a routine measure. He relies on **quinine hydrobromate** (gr. v *q.d.s.*) as a specific, having a neutralizing effect upon the excess of thyroid secretion assumed to be present; if quinine is not tolerated he gives **sodium salicylate** or **aspirin**. Hamilton Jones (N. O. Med. and Surg. Jour., Nov., 1913).

The symptomatic treatment is of importance in this condition.

Tremor, when intense, may be treated with tincture of **belladonna** or **hyoscyamus**. **Atropine** or **scopolamine**, $\frac{1}{120}$ grain (0.0005 Gm.) of either, might also be used, but a close watch must be kept over the patient.

Restlessness and insomnia should be treated with **mixed bromides**, **valerian**, or **chloral hydrate**.

Kocher advises the administration of **sodium phosphate** on the ground that thyroidectomized animals become cachectic when sodium phosphate and magnesia are removed from their food. Some observers have found **calcium chloride** useful in exophthalmic goiter. It may be given as follows:—

R *Calcii chloridi* ʒiiss (10 Gm.).
Syrupi aurantii florum. ʒv (20 c.c.).
Aquæ destillatæ,
 q. s. ad ʒv (150 c.c.).

M. Sig.: Three tablespoonfuls daily.

Parathyroid gland, in doses of $\frac{1}{10}$ to $\frac{1}{2}$ grain (5 to 25 mg.) thrice daily for limited and recurrent periods, has been recommended by S. Solis-Cohen for the purpose of controlling tremor and allied disorders.

The **surgical treatment** of the thyroid, judging from the results obtained, seems undoubtedly to be a treatment of great value, and to be applicable not only in the class of cases called "secondary," where an indolent goiter has been present for some years, but in the "primary" cases as well. The objection to it, as may be stated once for all, is the fact that a certain proportion—greatly reduced by improved methods in recent years—have ended fatally, owing perhaps, as suggested by Kocher, to the entrance into the exposed tissues of the toxic constituents of the

gland; but this view has not been generally accepted. The fact remains, however, that surgical procedures should not be adopted without an expressed willingness on the part of the patients and their friends to take a real risk and after judicious medical treatment has been fully tried. (See also the section on THYROID, SURGERY OF THE.)

Injections of **boiling water** have been used successfully by M. F. Porter, of Fort Wayne. Three deaths, however, have been recorded, due perhaps to imperfect technique.

Local discomfort from the **injection of boiling water** into the goiter, is slight; a fleeting headache is sometimes complained of. None of the 20 cases reported by Porter suffered any other untoward phenomena. Due care must be taken to avoid the large superficial veins and inject inside the capsule. The skin, after being cleansed, is anesthetized by Schleich's method. A large, glass, graduated syringe, with long, rather fine needle, is boiled in the water used for the injection. When more than 1 injection is given at 1 sitting, the syringe proper, handled with long forceps, is reboiled each time, to have the water always as near boiling as possible. "With a long needle different areas may be injected through the same skin puncture by partly withdrawing the needle. In this way both right and left lobes and the isthmus may be injected through 1 skin puncture, made in the center of the neck." The quantity injected by Porter varied from 40 to 230 minims (2.6 to 15.3 c.c.), the largest quantity in 1 treatment being 660 minims (44 c.c.). The immediate effect is destruction of thyroid tissue and colloid, a temporary increase in size and density being followed by contraction and subsidence of the general symptoms. M. F. Porter (Jour. Amer. Med. Assoc., July 12, 1913).

Porter's **hot water injections** often yield immediate improvement. One

death followed an injection at the Mayo clinic, but the case was one of extreme intoxication, recovery seeming impossible. Where but little improvement results from **rest in bed**, patients are sometimes sent home to continue the rest treatment; they usually return after several months in a condition permitting ligation with safety. D. M. Berkman (St. Paul Med. Jour., Oct., 1916).

Increasing experience emphasizes the necessity of skill on the part of the operator if he is to succeed with the injection method. The author prefers giving a hypodermic of morphine, and when the effect of this is manifest, injecting the boiling water without the knowledge of the patient. In carrying out the "cooking" process, a definite plan of attack should be borne in mind. The first infiltration should be made at the upper pole, and each succeeding injection carried downward, so that the destruction of gland is wrought in strata; unless some such order is maintained, one may unconsciously reinject a portion that has already been treated, thus delaying the improvement of the patient. When the gland is small, making the injection uncertain, good results can be obtained by exposing the thyroid, using local anesthesia, and making the injection directly into the goiter. With the gland exposed in this way the effectiveness of the process can be appreciated. As the boiling water is being injected, the corresponding portion of the gland is seen to whiten into a bloodless, pulp-like mass. J. C. O'Day (Annals of Surg., lxx, 279, 1917).

If possible the pregnant woman with a goiter should be tidied through the period of pregnancy. Often after the birth of the child the goiter will have disappeared. Crile has used injections of **quinine and urea** in the surrounding tissues to block nerve shock from the central zone. It would seem more logical to inject the drug into the capsule of the gland itself. It would act better than boil-

ing water, and as well as hot water. Three patients have died from injections of boiling water. The water need not be hot enough to coagulate albumin but enough to throw off the hormone of the gland more quickly. A great many cases have to be studied before one can make a definite statement as to results. C. S. Mayo (Med. Record, June 22, 1918).

For the preparation of substandard risks for the major operation **injections of boiling water** are to be preferred to ligations. Patients with small goiter of the diffuse, hyperplastic variety, may be cured with 1 or 2 injections, preferably through a small incision, uncovering the isthmus, so the operator can fill both lobes under guidance of the eye. M. F. Porter (Trans. So. Surg. Assoc.; Med. Rec., Feb. 15, 1919).

L. F. Watson employs instead injections of **quinine and urea hydrochloride**, also with encouraging results.

The writer uses injections of **quinine and urea hydrochloride** merely to relieve the symptoms of hyperthyroidism, and not to remove the goiter. They should always be made within the thyroid to avoid forming adhesions. Small infiltrations, often repeated, are best. Weak solutions have little effect; concentrated cause necrosis and connective tissue formation. In toxic goiter preliminary anesthesia is necessary. If acute hyperthyroidism is to be prevented, preliminary injections into the most prominent portion of the goiter of a few minims of sterile **salt solution**, at 1- to 3- day intervals, followed by injections of sterile water, are indispensable. The result of quinine and urea injections depends on the amount of tissue destroyed. Cases responding best are those of beginning hyperthyroidism not severe enough for operation. L. F. Watson (Texas Med. Jour., Oct., 1916).

In 125 cases, the writer deemed the **quinine and urea injections** not indicated in 25. In 100 cases the symptoms were relieved in 85 per cent. of

the exophthalmic, and in 84 per cent. of the toxic non-exophthalmic patients. Of the exophthalmic patients, 15 per cent. were improved and 10 per cent. of the non-exophthalmics were benefited. In 80 per cent. of the exophthalmic patients the goiter entirely disappeared within an average period of 5 months; in 15 per cent. the tumor was reduced in size and in 5 per cent. there was no change. The tumor disappeared in 75 per cent. of the non-exophthalmic patients; it was reduced in 12 per cent., and in 13 per cent. there was no change. These patients have been under observation from 2 to 4 years and there has been no recurrence of goiter or symptoms in any patient once cured.

The number of patients cured was highest in those who came early in the disease. The benefit received by those who came later was in proportion to the degree of damage done the circulatory and nervous systems by delay. Hyperthyroid cases must have at least a year of **mental and physical rest** after treatment. Watson (Ills. Med. Jour., Nov., 1917).

The **X-ray** treatment has been praised by many, though mainly as a palliative. It presents the drawback, however, of causing a radiodermatitis which leaves the skin brown. It should only be tried, however, when the medicinal and hygienic treatment has failed, when the symptoms are not sufficiently severe to warrant an operation, or when the surgeon refuses to operate.

The writer obtained very favorable results with the **X-ray** treatment of Basedow's disease in 41 cases. Of these, 14 are completely cured, 22 have derived great benefit, only 1 case proving rebellious. A small dose (less than enough to turn the Sabouraud pastille) is given for about seven to ten minutes, according to the tube. The anode is six inches from the skin. The amount of current used is $\frac{1}{2}$ to 1 milliampère. In acute cases treatments are given twice a week for a month. After a

fortnight's rest the treatments are resumed. For chronic cases once a week suffices. F. H. Stoney (Brit. Med. Jour., Aug. 31, 1912).

There are besides the above quite a number of methods which, in my opinion, owe their efficiency, as I have indicated, not to their specific effect, but to their general effect. The treatment of this class which I have found most valuable is persistent **faradization** or **galvanization** of the **thyroid gland** with strong currents. It is, perhaps, going too far to deny a beneficial local action to this sort of treatment of the gland. Certainly it is useful, whatever its mode of action. Through this means a large proportion of the patients presenting themselves at the Massachusetts General Hospital have been treated at different times, for long periods, and with marked benefit.

The other treatments which are occasionally useful are the **thyroid preparations** (especially useful in early stages and then sometimes extremely useful), the **thymus preparations**, and—it is said—the **suprarenal extract**, all of which should be given in as large doses as can be comfortably borne; **cardiac tonics**, especially **strophanthus**, the **neutral bromide of quinine**, **mild diet**, and **intestinal irrigation**. (See ANIMAL EXTRACTS: THYROID, THYMUS, and SPLENIC EXTRACTS, Volume First.)

Case of severe Graves's disease consequent on a miscarriage, in which the disease progressed rapidly. Three thousand units of **diphtheria antitoxin** were given. Within half an hour after receiving the injection she called for food and ate with apparent relish, retaining the food; the diarrhea ceased at once. Five days later the antitoxin was repeated, and again, about four weeks subsequently, because of the recurrence in

a mild form of the gastrointestinal symptoms. From the first administration the patient began to improve steadily, she gained weight, and her strength increased, though the **exophthalmos** became more pronounced. Life was made endurable, but the patient was still an invalid. About four months after this a portion of the thyroid was removed with marked improvements as result. Milroy (Western Med. Rev., Sept., 1907).

The writer used **diphtheritic antitoxin** in the treatment of **exophthalmic goiter** in 4 cases, with marked improvement as result. H. T. Walker (Iowa Med. Jour., Oct. 15, 1908).

The use of **pituitary extract** soon relieves the sleeplessness, tremor, disturbances of digestion, painful sensations of heat, and tachycardia. Arterial tension increases, **exophthalmos** decreases, and the goiter becomes smaller or remains stationary. When the extract is stopped the symptoms again increase. A. Salmon (Il Policlinico, Sept. 13, 1911).

Under medical treatment one may reasonably hope for the recovery of not less than 75 per cent. of patients exhibiting Graves's syndrome, and for permanency of the result in at least 80 per cent. of these. **Rest**, the most important measure of all, should include relief from worry or other mental disturbance, as well as from eye-strain and other sources of reflex irritation. As in tuberculosis, it is best for the patient to remain in the **open air** continuously. In many cases a **diet** consisting largely of raw or underdone broiled or roast beef and hot water is useful. One or two glasses of the hot water should be taken an hour before meals, and it should also be used between meals *ad libitum*. A minimum of sugars and starches, a sufficiency of green vegetables and fresh fruits, and milk and eggs, judiciously used, constitute the other essential features of the diet. In those patients who do not tolerate the usual large amount of beef,

pains should be taken to ascertain the articles of food best suited.

A potent influence in controlling some of the symptoms is re-education of the vasomotor tonus, by means of **alternate hot and cold applications**. After cooling the head and neck, the entire body should be sponged with water at from 108° to 112° F. (42.2° to 44.4° C.) and this immediately followed by a "**cold friction rub**" with water at as low a temperature as can be borne.

In respect of drug medication, the writer finds **thymus gland** in doses of 0.5 to 3 Gm. (7½ to 45 grains) daily, persisted in for months, frequently beneficial. The additional use, conjointly or alternately, of **adrenal preparations**, gives even better results. Intramuscular injections of a preparation of the posterior lobe of the **pituitary** will also often cause progressive improvement. Wherever the systolic blood-pressure is below 100 mm. Hg, either a pituitary preparation or **epinephrin** should regularly be given, with or without the thymus. **Thyroid gland** has, paradoxically, been known to do good in some cases, but should be used with the utmost caution. **Parathyroid extract**, in doses of from 0.005 to 0.025 Gm. (½ to ¾ grain) of the desiccated commercial preparation, given thrice daily for limited and recurrent periods, is also useful in many cases, especially in controlling tremor and allied nervous symptoms; its effect seems to be enhanced by combination with a calcium salt.

Intestinal antiseptics appear to be useful auxiliaries to treatment. In addition, it is well to wash out the colon thoroughly with **hot saline solution** once or twice weekly, and to give occasionally a course of **calomel** and **salts**, or **castor oil**. S. Solis-Cohen (N. Y. Med. Jour., from Amer. Jour. Med. Sci., July, 1912).

An alcoholic solution of **lecithin** has been found effective by Berkley, of Johns Hopkins, provided the patient be restricted to **milk diet**.

The writer found an alcoholic solution of **lecithin** excellent in exophthalmic goiter. Notwithstanding the nauseous and disagreeable odor of the solution, the patients cling to it until the nervous symptoms are allayed. All the patients placed on it state that an hour after the medicine was taken they were quieted and that there was cessation of acute symptoms. The writer tried it for alternate weeks with glycerophosphates, quinine, and gentian, but the patients lost weight, with increase of nervous phenomena on the glycerophosphates, while they gained weight, with abatement of nervous symptoms, on the lecithin. Lecithin is out of place with disturbed digestion, and it fails without the assistance of a milk diet. H. J. Berkley (Bull. Johns Hopkins Hosp., Sept., 1908).

Kocher recommends as preparatory measures a sojourn at some resort having an **elevation** of 1000 to 15,000 meters (3300 to 4900 feet), **cool baths and lotions**, a diet poor in albumin and fats, a **rest cure** interrupted by **systematic exercises**, and the internal administration of **phosphorus**, **arsenic**, and **iron**. Measures which produce a rise in the blood-pressure, as well as active diuretics, are to be avoided.

The writer regards a **sanatorium environment** at an **altitude** of from 2400 to 5400 feet as by far the most effectual measure in the majority of cases. Among drugs he places most reliance on **arsenic**, long continued and repeated, with pills of **iron**, **quinine**, and **nux vomica**, to alternate with the arsenic. **Bromides** are indispensable, but he warns against iodides and digitalis, preferring **strophanthus** in case of heart neuroses. Erb (Med. Klinik, Jan. 5, 1908).

Salvarsan, though only tried in one case at the time of this writing, produced favorable results. This may be

accounted for by the fact that all arsenical preparations tend to inhibit the functional activity of the thyroid apparatus.

Case of Graves's disease with scleroderma and a positive Wassermann reaction treated with **salvarsan**, in a married woman 28 years of age. There was no history or clinical evidence of syphilis. In a son 7 years of age and in the husband the Wassermann was negative. Two intramuscular injections of salvarsan of 0.5 Gm. ($7\frac{1}{2}$ grains) each were given. This was followed by a gain of 30 pounds in weight, considerable diminution in the thyroid swelling, disappearance of the nervous symptoms and the tachycardia. H. F. L. Ziegel (Med. Rec., June 21, 1913).

JAMES J. PUTNAM, Boston,

AND

THE EDITOR.

GRINDELIA.—Grindelia is the leaves and flowering tops of *Grindelia robusta* and *Grindelia squarrosa*, which are herbaceous perennial plants indigenous to Mexico and the Pacific coast of the United States. They contain a resin, a volatile oil, and an alkaloid (grindeline).

PREPARATIONS AND DOSES.—

Grindelia (leaves and tops), $\frac{1}{4}$ to 1 dram (1 to 4 c.c.).

Fluidextractum grindelie, U. S. P. (fluid-extract of grindelia), $\frac{1}{2}$ to 1 dram (2 to 4 c.c.).

PHYSIOLOGICAL ACTION.—Grindelia has an acrid, bitter taste. When chewed it excites the secretion of saliva. It is an antispasmodic, motor depressant, and has light expectorant and diuretic action. It slows the heart and increases the blood-pressure. It stimulates the bronchial membrane and the kidneys, and is eliminated by them. When given in large doses, it induces paralysis of the peripheral sensory nerves, the sensory centers in the spinal cord, and later the motor centers and nerve-trunks; the pupils become dilated and renal irritation is produced.

In warm-blooded animals the phenomena which grindelia robusta pro-

duces may be ascribed to an exciting action upon the bulbar center of the pneumogastric, which when a large dose is introduced at one time into the circulation, appears to be paralyzant. The effects upon blood-pressure are that with small doses there is a slight rise, which is more evident with medium doses; but as the amount is increased the pressure gradually and continually falls during the same time that the oscillations are shorter. When its effects on the pneumogastric are considered and also its power of contracting bronchial muscles and its action on the heart, it is likely, in proper doses, to be of value as a remedy for the symptoms of asthma. The drug contains an active principle, likely terpene, which benefits the associated catarrh. The drug apparently possesses a paralyzing action on the thermogenic center. The secretions are affected as follows: The urine is increased by small and diminished by large doses, partly from changes in blood-pressure and partly from direct action on the renal epithelium. The saliva and bile are increased. Both urine and saliva are of greenish tinge. Luigi d'Amore (Giornale della Assoc. Napolitana di Medici e Naturalista, Puntata 5a e 6a, p. 331, 1896).

THERAPEUTICS.—Spasmodic asthma and bronchitic dyspnea may be relieved by the fluidextract of grindelia in doses of $\frac{1}{4}$ to 1 fluidram (1 to 4 c.c.), every three or four hours, given preferably in a little sweetened water or milk. In recurrent asthma it often affords prompt relief, but it does not prevent the return of the paroxysms. It is also beneficial in **spasmodic coughs, pertussis, chronic bronchitis**, and in **hay fever**. The leaves of grindelia soaked in a solution of nitrate of potash and dried may be burned or smoked, and the fumes inhaled.

In **emphysema grindelia robusta** according to Huchard facilitates the respiration and expectoration. In simple **cardiac hypertrophy** and in **dilatation** it has all the advantages of digitalis without any of its drawbacks. It relieves **pulmonary congestion** and the **palpitation** associated with

cardiac hypertrophy, emphysema, asthma, and incipient tuberculosis. The following formula is useful:—

R *Tincture of grindelia* 6 parts.
Tincture of convallaria 2 parts.
Tincture of squill 1 part.

Fifteen drops three times a day.

In **chronic cystitis** it gives relief by stimulating the mucous membrane of the bladder. The fluidextract diluted with water (1 to 10) is a very valuable lotion in **poison-oak or poison-ivy eruption**, and in pruritic skin affections. W.

GUAIAIC.—Guaiac-wood (*Guaiaci lignum*) is the heart-wood of *Guaiacum officinale* (*Lignum vite*). It is of olive, brown, or yellow color, very hard, and has a faint, aromatic odor and a pungent, acrid taste. The wood furnishes a resin (*guaiacum*, U. S. P.), which is brittle and breaks with a bright, lustrous fracture. Its odor and taste are the same as that of the wood. Its powder is grayish, but becomes green on exposure to the air. It is soluble in alcohol, ether, and alkaline solutions, but very slightly so in water. Guaiac resin is an ingredient of Plummer's pills (*pilule anti-monii compositæ*).

PREPARATIONS AND DOSES.—*Guaiacum*, U. S. P. (resin of guaiac); dose, 10 to 30 grains (0.6 to 2 Gm.).

Tinctura guaiaci, U. S. P. (tincture of guaiac); dose, $\frac{1}{2}$ to 1 dram (2 to 4 c.c.).

Tinctura guaiaci ammoniata, U. S. P. (ammoniated tincture of guaiac); dose, $\frac{1}{2}$ to 1 dram (2 to 4 c.c.).

PHYSIOLOGICAL ACTION.—Guaiac taken internally causes a sense of warmth in the stomach, and increases the secretion of the digestive fluids. In large doses it gives rise to gastrointestinal irritation and produces active purgation. A well-marked rash, attended with great itching and resembling that of copaiba, sometimes follows the use of guaiac.

The reaction of leucocytes to guaiac depends on the oxidizing effect of nucleoproteids in the pus-cells; possibly due to a fermentation which could not be separated from the other substances. The nucleoproteids of the liver, spleen, and thymus are all capable of breaking down

hydrogen peroxide, but do not turn guaiac tincture blue. Only one tissue of all those examined was able to produce the same reaction with guaiac as pus, namely, bone-marrow, leukemic blood, even in the smallest quantities, in marked cases turns guaiac tincture blue. Brandenburg (Münch. med. Woch., Feb. 6, 1900).

THERAPEUTICS.—Guaiac given early in a 30-grain (2 Gm.) dose, either in powder or in emulsion with the white of egg, will often abort an attack of **acute tonsillitis** or of **acute pharyngitis**. **Rheumatism** of subacute or chronic type, and **rheumatic pharyngitis** may be relieved by the administration of either the tincture or the ammoniated tincture of guaiac; but, on account of its disagreeable character, other remedies are preferred.

Guaiac is valuable in **gouty conditions**. According to Garrod it possesses the following advantages: (1) It is innocuous, and may be taken for an indefinite length of time. (2) It possesses considerable power, but less than colchicum, in directly relieving patients suffering from gouty inflammation of any part; it may be given whenever there is but little fever. (3) Taken in the intervals of gouty attacks, it has a considerable power of averting their occurrence; in fact, it is a very powerful prophylactic. (4) It does not seem to lose its prophylactic power by long-continued use. (5) There are a few patients who cannot continue its use. Guaiac does not affect the formation of uric acid, but acts directly on the kidneys as a stimulant, enabling them to get rid of any accumulation in the tubules, thus preventing absorption from them into the blood.

Amenorrhea.—In amenorrhea not associated with anemia, the administration of 10 grains (0.6 Gm.) of guaiac, stirred in milk, before breakfast, will give good results if continued for some weeks. **Painful menstruation** may be relieved by the ammoniated tincture in doses of $\frac{1}{2}$ to 1 dram (2 to 4 c.c.) every two or three hours. W.

GUAIACOL.—Guaiacol (monomethylcatechol, methyl ether of pyrocatechin; methylpyrocatechin) is a

highly refractive, colorless, oily liquid, having a characteristic aromatic, agreeable odor, and is obtained by fractional distillation from beechwood creosote. It may also be obtained by the dry distillation of guaiacum, or produced synthetically by the action of methylsulphuric acid upon pyrocatechin. It is freely soluble in alcohol, ether, and carbon disulphide, and in 85 (Helbing) or 200 (Merck) parts of water. It also occurs in colorless crystals, which are freely soluble in glycerin, alcohol, ether, and slightly soluble in water. It forms salts with the acids; the carbonate and salicylate is a white, insipid, crystalline substance, with the odor of salol, and soluble in alcohol.

According to Winghoffer absolutely pure, crystalline guaiacol has little taste or smell. It can be obtained in an absolutely pure condition from a commercial sample by cooling with a mixture of ice and salt, and then separating the crystals which have formed.

PREPARATIONS AND DOSES.

—*Guaiacol*, U. S. P. (guaiacol—liquid), which contains 60 to 90 per cent. of creosote; dose, 2 minims (0.12 c.c.), gradually increased to 16 minims (1 c.c.).

Guaiacolis carbonas, U. S. P. (guaiacol carbonate); dose, 3 to 8 grains (0.2 to 0.5 Gm.), increased to 90 grains (6 Gm.).

Of the other preparations of guaiacol, such as the succinate, salicylate, benzoate, biniodide, etc., none has shown material superiority over the official product when pure.

PHYSIOLOGICAL ACTION.—

The physiological action of guaiacol is similar to that of its congener, creosote, although its effects on the

gastrointestinal tract are not so irritating. The respiration and pulse are only temporarily affected. The blood-pressure is slightly increased, and there is slight contraction of the arterioles. Large doses produce a burning sensation in the stomach, nausea, etc.: symptoms of gastrointestinal irritation. Guaiacol is excreted principally by the kidneys, as guaiacsulphuric ether, but also by the skin and the salivary glands, and in small measure by the lungs.

Guaiacol lowers the temperature when applied to the skin by influencing the peripheral ends of nerves, and, through them, the thermogenic center. This influence of guaiacol is chiefly seen in febrile conditions.

After painting the skin with 2 Gm. (31 grains) of guaiacol, elimination by the kidney is manifested in a quarter of an hour. The proportion in the urine is greatest in from one and a half to four hours, and reaches 50 grains (3½ Gm.) per quart (1000 c.c.). It decreases rapidly in six or seven hours, and in twenty-four hours there is no further trace in the urine.

POISONING BY GUAIACOL.—

A case of poisoning, in a child 9 years of age, has been reported by Wyss, in which 1¼ drams (5 Gm.) were accidentally taken. In a short time she became unconscious and cyanotic. The conjunctivæ became injected, the corneal reflexes diminished, and the pupil contracted and inactive. Vomiting (ejecta had odor of guaiacol) and profuse salivation were present. The pulse became rapid and weak and the breathing irregular. Cutaneous sensibility was diminished. Later on blood and bile-stained mucus were vomited. The urine was dark colored, of an aromatic odor, and contained

bile-pigments and a small amount of albumin. The cyanosis gradually diminished and was followed by a deadly pallor. The respirations became frequent. Jaundice appeared and the patient died on the third day. The autopsy revealed an acute gastro-enteritis and parenchymatous degeneration of the liver and heart muscle, acute hemorrhagic nephritis, enlarged spleen, and ecchymoses in the pleura, peritoneum, endocardium, and pericardium. Several cases of death have been reported following the hypodermic administration of guaiacol, the patients dying within an hour in profound coma with every symptom of cardiac paralysis.

Fifteen and a half minims (1 c.c.) of a mixture of guaiacol, 150 parts, and iodoform, 20 parts, injected into the knee-joint of a girl of 8 years suffering from fungous arthritis gave rise to cyanosis, dyspnea, loss of consciousness, nausea, and temporary amaurosis supervened. Von Mosetig-Moorhof (Deut. med. Woch., No. 7, 1894).

Guaiacol is absorbed rapidly. Fifty to 60 minims ($3\frac{1}{2}$ to 4 c.c.) are applied to the surface and the part is covered with oiled silk. Within fifteen minutes the pulse relaxes, the skin becomes cool and moist, and the temperature begins to fall. The effect lasts for four or five hours. The application may be repeated night and morning, according to the course of the fever. This means of employing this remedy should be used with care, as it is, when used in this way, that ill effects generally occur. On account of the rapid absorption of the drug, the fall of temperature may be rapid, descending below the normal, with cold extremities, clammy skin, feeble pulse, and other conditions of threatened collapse. Guaiacol is best applied mixed with equal parts of glycerin or oil. E. S. McKee (Med. Bulletin, Feb., 1907).

Treatment of Guaiacol Poisoning.

—Soluble sulphates (Epsom or Glauber's salt) may be given freely in conjunction with mucilaginous drinks. *Digitalis* and *strychnine* hypodermically injected are useful, associated with heat to the extremities and counterirritation applied on the abdomen. Emetics and the stomach-pump are valuable if used early, before the drug has been absorbed.

THERAPEUTICS.—Guaiacol has been chiefly used as a remedy in **tuberculosis**, and as an antipyretic in **fever**. It may be given in pill, in capsule, in an alcoholic or oily solution, or by hypodermic injection, dissolved in sweet almond oil (equal parts), or in sterilized neutral olive oil (1 to 5). Liquid guaiacol may be administered by inhalation, its volatility adapting it for that purpose. It may also be given by inunction; the part being cleansed and dried, the guaiacol is painted over the surface, and after being left for about ten minutes the part is well rubbed and covered with some impermeable dressing. Its absorption is very rapid, guaiacol being found in the urine fifteen or twenty minutes after it is applied to the skin.

Pulmonary Disorders.—In the early stage of tuberculosis guaiacol reduces the fever, restores the gastric and intestinal functions, and improves the condition of the patient. These effects have been ascribed to a bactericidal action on the specific bacillus and also to the formation of a compound with the toxins which annulled their pathogenicity, but the correctness of these views has not been shown. Its action, however, is probably similar to that of creosote (*q.v.*), which it contains in large proportion.

Bard and others found that the local application of guaiacol caused a marked reduction of the temperature. It may be painted over the thigh or the back, the part being covered with an impermeable towel. Dosage can thus easily be managed. The quantity at the beginning was $\frac{3}{4}$ dram (3 c.c.), this amount being decreased at each treatment. Sajous has found this procedure very depressing in advanced tuberculosis. The antipyretic action of guaiacol was not confined to tuberculous cases, but has given satisfactory results in the acute pyrexia of **pneumonia**.

Surgical Tuberculosis.—The liquid may be used as a 1 in 10 to 1 in 20 solution in sterilized olive oil. Rigid antiseptic precautions are required for the injections, the latter being made with a Roux syringe deeply into the granulation masses, $\frac{1}{2}$ to 1 c.c. (8 to 16 minims) of the solution being injected at three or four different points. This may be repeated once or twice every week, provided there has not been much irritation.

Guaiacol may also be used in the form of a dressing in certain open tuberculous conditions: thus gauze steeped in guaiacol solution (in olive oil, 1 in 10) and applied to the surface causes decrease of pain and induces a healthy condition of the tissues.

Fever.—Guaiacol possesses strong antipyretic powers. It is perhaps best used by painting over the skin of the abdomen, the chest, or the internal aspect of the thigh, 30 or 40 drops being used for this purpose, as described above. These applications may be repeated. The decline in temperature is often great and rapid, but after reaching the lowest point the temperature will more rapidly attain

its former height. A great feeling of depression is experienced by the patient and profuse sweating occurs when the temperature reaches the minimum, and chills at this time are not uncommon. The use of this drug for its antipyretic effect is not devoid of danger, and its action is not as lasting as that produced by the cold bath and by numerous other antipyretic remedies. Guaiacol carbonate has been used in typhoid fever, for its antiseptic action in the bowel, but such use is not to be advised.

J. M. Da Costa noted that on painting the skin with guaiacol in a case of **typhoid fever**, the temperature fell from 105.4° to 98.6° F. (40.7° to 37° C.) in three and a half hours without any disturbance of the circulatory or nervous system. Afterward the drug was used about twice daily, a fall of temperature occurring each time. The antipyretic effect is slower than that of the bath, but more permanent. After washing with soap and water, 30 drops should be slowly rubbed in the skin of the abdomen or thigh or painted over the surface, then covered with lint or wax-paper. Fifty drops should be the maximum amount. The urine should be watched carefully. The unpleasant odor caused by the drug may be to some extent overcome by the addition of oil of cloves.

This use of guaiacol is not recommended by Stolzenburg, Friedenwald and Hayden, and others. Although the fall of temperature is very marked, the sweating and rigors are very severe, and the influence on the disease is not lasting.

Great exhaustion is frequently produced. The effects may be obtained from 30 to 50 drops, and great care should therefore be exercised, the

drug being applied but once or twice daily, the initial dose not exceeding 30 drops. Its effect differs from the stimulating cold bath in being depressant. The main indication for its use is in diseases accompanied by high fever in which the cold bath cannot be applied, as well as in all other diseases accompanied by high fever in which irritability of the stomach prevents the use of other antipyretics.

Guaiaicol has been used in the treatment of **malarial intermittent fevers** by Rogers and others; 15 minims (1 c.c.) were rubbed into the axilla and covered with cotton. The average fall of temperature in three-fourths hour was 1.6° , in one and three-fourths hours 2.3° , and after four hours the average fall was 3° . The fall of temperature was accompanied by a free perspiration and a marked improvement in the condition and comfort of the patient. No depression was noticed.

Guaiaicol must be used with great care, both internally and externally. It has been used internally in **malaria** with success, in doses as high as 45 drops, after meals; and as much as 40 drops have been used over the abdomen three times a day with good success in malaria. When the stomach is irritated during malaria the external use of this remedy should not be lost sight of. In **toothache**, when the tooth is hollow, 1 drop on cotton put in the tooth will generally relieve it; but as small a quantity as 2 drops in a hollow tooth have produced poisonous effect. In **earache** it should be diluted with an equal part of olive oil, and 2 drops put in the ear. The external use of guaiaicol gives satisfactory results in relieving most **pains**. In **continued fever** its external use over the abdomen will satisfactorily control the temperature, and it is used externally in **abscesses**, **epididymitis**, **orchitis**, **gout**, **neuralgia**,

neuritis, **pleurisy**, **pneumonia**, **rheumatism**, and applied on the tonsils with equal parts of olive oil in **tonsillitis**. J. A. Burnett (Wisc. Med. Recorder, vol. vi, No. 6, 1903).

The writer used guaiaicol dissolved in olive oil (1 in 80) in the treatment of **variola**, having applied this oily solution at intervals of four hours to the affected skin. The results were decidedly beneficial, not only upon skin lesions, but also upon the fever. Out of 44 cases of confluent variola only 1 terminated fatally, which favorable result was ascribed by the author to the guaiaicol treatment. J. Ridge (Brit. Med. Jour., p. 1257, vol. i, 1903).

The local application of a 10 per cent. ointment of guaiaicol and salicylic acid is an excellent remedy for **exudative pleuritis** and **rheumatic joint affection**. Fluid which has persisted for weeks, despite internal remedies, is quickly absorbed and the pain of **rheumatism** is soon alleviated. Though pure guaiaicol applied endermatically may give rise to symptoms of intoxication, these are never observed in a dilution of 10 per cent. The only disadvantages is that the skin becomes like parchment after several applications and absorption is no longer so active; hence it is advisable to select a different portion of the body every time. D. Hecht (Münch. med. Woch., Feb. 28, 1905).

Painful Disorders.—The analgesic effects of guaiaicol have been utilized in the treatment of **arthritis deformans**, **neuralgia**, **neuritis**, **acute articular and muscular rheumatism**, **sciatic coxalgia**, and **pains** of a superficial or deep-seated nature. The pains of **orchitis** and **epididymitis** are relieved by applying guaiaicol in oily solution or in ointment (1 part to 10 or 15 of vaselin or lanolin).

Guaiaicol has been recommended in cases of **gonorrheal orchitis** by Tavittian. Crystalline guaiaicol after previous melting may be applied to the

affected part and to the groin by a brush; 31 to 46 grains (2 to 3 Gm.) may be used each time. A guaiacol ointment may be made thus:—

R Guaiacol $1\frac{1}{4}$ drams (5 c.c.).
 Petrolatum $1\frac{1}{3}$ ounces (50 c.c.).

Lenz, in the cases of **epididymitis**, of **gonorrheal** origin, uses 10 per cent. ointment made with vaselin or a 5 per cent. used if the skin of the scrotum is tender. The scrotum is first washed with soap and with ether. This ointment is applied during the acute stage, and in from three to five days the fever, pain, and swelling disappear. In subacute stages the action of guaiacol is less active and very slight in chronic cases. After the acute stage it is best replaced by a 1 or 2 per cent. ointment of extract of belladonna, with equal parts of simple ointment and unguentum diachylon. Salol internally, 15 grains (1 Gm.) *ter die*, is a useful adjunct to the treatment.

The writer regrets that guaiacol is not used more for external application as its properties deserve, especially in local treatment of **neuralgia**, **neuritis**, **gout**, **chronic rheumatism**, and **traumatism**, in the form of a salve, and for application to the surface of the chest in lung, pleura, and febrile affections. He advocates a 10 per cent. solution or salve and observed excellent results from it in various cutaneous lesions, including **erysipelas**, **furuncles**, and **herpes zoster**. There are no untoward by-effects unless too large doses are used, over 1.5 to 3 Gm. ($22\frac{1}{2}$ to 45 grains). Hecht (Therap. der Gegenwart, July, 1909).

Anesthesia.—As an anesthetic guaiacol may be used in minor surgical operations. A dose of 1 or 2 drops dissolved in sterilized olive oil is sufficient to obtain anesthesia; five minutes should be allowed to elapse

after the injection. Championnière considers guaiacol superior to cocaine, because much larger doses may be used with safety. No accidents were noticed except slight sloughing of the gums where it had been used for the extraction of teeth, which he attributed to a faulty method of injection or to a defective solution. Applied to **burns** in solution, 10 per cent., in olive oil, it causes a disappearance of the pain. Anesthesia is less rapidly produced than with cocaine, being complete only after seven or eight minutes; on the other hand, however, it appears to be much more durable. Anesthesia is induced even in inflamed tissue.

Erysipelas.—Guaiacol dissolved in alcohol or oil has been employed as an application in this disease. Twenty to 30 drops may be painted over the infected area and slightly beyond. The pain is promptly relieved and the temperature lowered by this method of medication.

Excellent results were obtained by the writers from tamponing **purulent wounds** with gauze moistened with 20 to 30 drops of pure guaiacol. It even arrested the morbid process in one case of **fulminating gangrene** requiring amputation of the arm. After the operation the extension of the process in the muscles of the shoulder was completely checked by the guaiacol dressing. Prochorov and Bialobjesky (Semaine méd., vol. xxiv, No. 40, 1904).

The writer has been using for some time a mixture containing 1 dram 4 c.c.) each of guaiacol and ichthyol to the ounce of glycerin as a local antiseptic in the treatment of **infected wounds**. His results have been excellent. Gilbert (New Mex. Med. Jour., Aug., 1911).

C. SUMNER WITHERSTINE,
 Philadelphia.

GUARANA.—Guarana is a dried paste, consisting chiefly of the crushed or pounded seeds of *Paullinia cupana* (*Paullinia sorbilis*), a climbing plant in the eastern part of South America, and especially in Brazil. It contains an alkaloid, guaranine, which is identical with caffeine and theine. Guarana is slightly soluble in water as well as in alcohol.

PREPARATIONS AND DOSES.—*Guarana*, U. S. P. (guarana); dose, $\frac{1}{4}$ to 2 drams (1 to 8 Gm.).

Fluidextractum guaranæ, U. S. P. (fluid-extract of guarana); dose, $\frac{1}{4}$ to 2 drams (1 to 8 c.c.).

PHYSIOLOGICAL ACTION.—Guarana has a slightly bitter and astringent taste. It contains sufficient tannin to give it a slight astringent action. Farther than this, its physiological action is that of caffeine.

THERAPEUTICS.—It is most frequently given for sick headaches or migraine. It is especially recommended when the pain affects the right side of the head. It shortens the attacks and in-

creases the interval between them. From 30 to 60 grains (2 to 4 Gm.) of the powder, or an equivalent of the fluidextract, may be taken every night and every three hours during the attack. It is also given as a tonic when nerve-action is impaired, as in **convalescence** from acute disease, debility, etc. W.

GUINEA-WORM DISEASE.

See PARASITES, DISEASES DUE TO.

GUNSHOT WOUNDS OF ABDOMEN. See ABDOMINAL INJURIES.

GUNSHOT WOUNDS OF BRAIN. See HEAD AND BRAIN, DISEASES OF.

GUNSHOT WOUNDS OF HEAD. See HEAD AND BRAIN, DISEASES OF.

GUNSHOT WOUNDS OF STOMACH. See ABDOMINAL INJURIES.

GYPSUM. See CALCIUM.

H

HAIR, DISEASES OF THE.—

The main disorders of the hair, ALOPECIA and ALOPECIA AREATA, will be found treated in full in the first volume. SEBORRHEA is also treated under that head.

ATROPHY OF THE HAIR.

Physiological Atrophy.—Each hair has a certain span of life upon the completion of which it undergoes a physiological atrophy; it becomes separated from its papilla, which atrophies, a new papilla and a new hair being formed from the old follicle. Klein tells us that the lower part of the follicle, including the hair-bulb, degenerates also, and is gradually absorbed. There is then left only the upper part of the follicles and the hair-root, the fibers of which become fringed at the distal end and lost among the cells of the outer root-sheath, constituting the *hair-knob of Henle*. Later a cylindrical outgrowth of epithelial cells projects downward from the outer root-sheath and becomes invaginated over a new papilla.

Cell proliferation and multiplication follow and a new hair-bulb and hair are formed, and the old hair is gradually pushed out of the follicle as the new one slowly makes its way to the surface.

Pathological Atrophy.—Occasionally the hair undergoes a premature or pathological atrophy in its structure. Change takes place in part or all of its length, the diameter either increasing or becoming less. In one form, known as **trichorrhexis nodosa**, small, bulbous swellings having a dark or shiny appearance are found on the shaft of the hair at a single point or at irregular intervals. The hair becomes fragile and is liable to break off between and at these nodosities, leaving a ragged, brush-like end. These nodes occasionally result from the collection of pigment in the swellings, in the hairs presenting alternately bright and dark color, causing great disfigurement by the bead-like effect in the mass of hair. This form of atrophy is generally

confined to the beard and mustache, but is occasionally found elsewhere. A similar condition known as **piedra** is common in Colombia and has been called **tricomycose nodulaire** by Juhel-Rénoy, who states that the nodes are formed by masses of very refractive spores glued together by a greenish-yellow material constituted by compact colonies of rods. The diameter of the spores is about 0.01 mm., somewhat larger than those of trichophytosis. This parasite is wholly exterior to the hair.

Remarkable wholesale incidence of trichorrhæxis nodosa among school-girls. In addition to the manifest brittleness of the hair, the latter presented even to the naked eye the characteristic nodosities. The microscope showed the presence of the longitudinal fission. No sort of parasite could be found. The writers'



Trichorrhæxis nodosa

material appears to show, perhaps for the first time, that a predisposition is necessary for the development of this affection under ordinary circumstances. This was evident because the nutrition of the nails and teeth showed manifest defects. Hübner and Walter (Münch. med. Woch., Jan. 16, 1912).

Fragility of the hair is another variety of atrophy, characterized by a brittle and cleft state of a part or the whole of the hair substance, often within as well as without the hair-follicle. This form is generally found on the head and beard, where the hairs are irregularly thin or flattened, rough, uneven along the shaft, brittle at points, breaking off and splitting up, often into several fibrillæ. When the follicle is the seat of the alteration, the hairs may be found curled up within it; this often causes considerable irritation in the integument, especially in the region of the beard and of the lower limbs. Atrophy may be slight or marked; in the latter case great deformity is produced through the marked changes induced.

Moniliform hair is a rare form of atrophy of the hair in which nodular or fusiform swellings and narrow atrophic portions alternate all along the entire hair-shaft. The nodes are darker, giving a ringed appearance to the hair, which is brittle and inclined to break in the internodular portions, leaving the ends frayed and brush-like. This brittleness may cause most of the hair to break off near the scalp and leave bald patches resembling somewhat those produced by tinea tonsurans. Treatment is unsatisfactory.

The writer reports a marked case of moniliform hairs occurring in a boy aged 5 years. The affection began soon after birth, and was accompanied by a well-defined hyperkeratosis of the follicles not only on the scalp, but on the shoulders and extensor surfaces of the extremities. There was a distinct history of heredity, the father, a paternal aunt, and a cousin suffering from the same disease. The author believes that the spindle-like enlargements upon the hairs result from mechanical causes rather than from any pathological process. Bering (Archiv f. Dermat. u. Syph., Bd. lxxv, H. 1, 1906).

ETIOLOGY.—Atrophy of the hair may result from either local (seborrhea, eczema, parasites) or constitutional diseases (phthisis, malaria, syphilis, excesses of various kinds).

TREATMENT.—Remove the exciting cause, if possible. Re-establish nutrition by the use of tonics, **codliver oil**, and small doses of **sodium arsenate**, or **arsenic trioxide**. Pluck out the diseased hairs, or if they are numerous remove the diseased ends and rub into them a 10 per cent. ointment of **oleate of mercury**, once or twice daily. The entire surface of the scalp may be shaved, if a large number of hairs are involved, but it is preferable to cut off the affected ends. A close haircut will in more cases yield better results than shaving. Other forms of **mercury** (**nitrate** or **ammoniated**) may be used in ointment (1 to 8 or 1 to 16) with benzoated lard, with or without lanolin as a base. In addition to these, proper hygiene

of the scalp and stimulating lotions should be used. In most cases bland ointments to the scalp are beneficial.

Proper care of the hair and scalp will lessen or avert the tendency to atrophy.

CANITIES.

SYNONYMS.—Atrophy of the hair-pigment; grayness; whiteness or blanching of the hair; trichonosis; poliosis discolor.

In the consideration of atrophy of the hair we meet a condition in which there is a local or universal, partial or complete, loss of color in the hair due to atrophy of the hair-pigment.

This condition may be either congenital, premature, or the result of increasing age. The congenital form is met with in albinos. Premature grayness generally develops slowly, but many cases are recorded where the hair has turned suddenly gray or white within a few hours, or overnight.

The writer reports the case of a woman aged 48 who, while nursing a sister ill with some neuropathic affection, became herself melancholic. Her hair became uniformly thin and snow-white. As her health returned, a new and luxurious crop of dark-brown hair appeared. Jovel (Zeit. f. Hypnotismus, Bd. vii, H. 3, 1898).

Case observed in an insane-asylum. Upon admission his hair was of dark color both on the scalp and face. Within the short period of five weeks, it changed first to a gray and then very rapidly to a distinct white. There was no history in his family of any insanity, immediate or remote. R. Jones (Lancet, March 1, 1912).

ETIOLOGY.—Canities may be caused by any of the internal derangements which give rise to alopecia. A gradual or sudden atrophy of the hair-pigment may be brought about by cares, worry, anxiety, prolonged mental strain, shocks, and all conditions that profoundly impress the nervous system.

Certain foods and drugs, change in habits, seasons, and climate, and increase in age will cause atrophy of the hair-pigment. Arsenic or pilocarpine given internally has produced this effect. Exposure

to air and sun, exposure to chemical action, are active causes.

The writer believes that there is a large group of cases in which gray hair is acquired in association with nerve lesions, and therefore probably is connected with these changes. He reports 2 cases to illustrate his contention. His endeavor is to show that in such cases there is an epithelial change which takes place *pari passu* with the change in the nervous system, and which is probably due to it. Cheatile (Brit. Med. Jour., Aug. 31, 1912).

PROGNOSIS.—Premature canities is usually permanent. Rare cases have been reported where the pigment has returned to the hair, but these have generally been caused by some acute disease.

TREATMENT.—By the use of appropriate systemic treatment the change of color in the hair may sometimes be arrested in young persons, or may be concealed by the employment of agents that will, to a moderate degree, color the hair-substance. Useful remedies in this line are the **oils of walnuts**, of **eggs**, of **mace**, and of **cassia**. J. V. Shoemaker suggests a walnut hair-dye, prepared by bruising 40 parts of fresh green walnut peel with 5 parts of alum, and digesting with 200 parts of olive oil until all moisture has been driven off, straining and perfuming. **Sage tea** is useful, the hair being frequently sponged and washed with it. **Tannic** or **gallic acid** in oil, glycerin, or lard (1 to 8) often darkens the color of the hair. Gray or white hairs, if not too numerous, may be treated with any of the foregoing preparations, or they may be plucked out. If the grayness has become extensive, it can be concealed only by dyeing the hair.

The usual methods of dyeing the hair are given here to familiarize the reader with the subject, in order to enable him to meet untoward effects the use of hair dyes sometimes entails.

The proper use of hair-dyes implies a knowledge of the agent employed, the skill to increase or decrease its strength according to the shade required, and, finally, dextrous manipulation. Before using any dye the hair should be cleansed

with soap and water or with a solution of soda or of ammonia, and allowed to become thoroughly dry (usually takes an hour). The mineral dyes are the most active. The vegetable dyes are feeble in action and uncertain in effect, especially when used by an unskilled person, but, on the other hand, are generally less harmful, except, perhaps, pyrogalllic acid, the use of which may give rise to alarming symptoms. The most valuable vegetable dye is the Eastern or Persian combination of powdered dry **henna** and powdered **indigo plant**. These are mixed separately with water to form a thick paste. The henna paste is first spread on the hair. In the course of an hour a red color is obtained. The indigo paste is then applied in like manner. After the lapse of several hours, the hair is well washed with water and it is found to be dyed a deep black. Another method is to moisten the hair with a solution of **ammonium anacardate** (a doughy substance soluble in water), and then comb it with a comb dipped in **ferrous sulphate** (Gawalowsky). **Iron oleate** may be used instead of the sulphate, and the anacardate may be used in the form of an ointment or mixed with oil. **Chrysarobin**, **goa**, or **araroba powder** in ointment (1 or 2 in 8) with lard imparts a dark-blue color to the hair. **Pyrogalllic acid** stains the hair a dark brown, and may be used in ointment or in solution with cologne and rose water. A brown color is also produced by the **salts of iron**.

Nitrate of silver in ointment or solution (1 to 4 in 32) is the best mineral dye. Shoemaker uses the following method of application, using a solution by preference: With a good-sized comb in the left hand, the operator lifts up the locks of hair, and, with a soft, long-bristled tooth-brush in the right hand, the dye is brought carefully in contact with the hair. The brush is moved up and down, rubbing the dye well in toward the hair-follicles, for, by reason of the arrangement of the hair-cells, the silver oxide, as it decomposes from the menstruum, is thus best communicated to the hair-substance. The dye should be kept from contact with the skin, and the hair should be quickly dried by rapidly fanning it. Any

stain on the skin is removed by a solution (1 in 32) of potassium iodide, of sodium sulphide (2 in 32), or even salt and water. The whole process requires from two to three hours, and must be repeated every four to eight weeks. The best blonde bleach is **dioxide of hydrogen**, but light shades may also be obtained through the use of **turmeric** or **rhubarb**.

Eighteen cases of irritating effects from a preparation the base of which was chloral and paraphenyldiamine. The eruption was seated along the border of the hair and beard and part of the face, and was erythematous in character, the eyelids swelling; where hair was present the eruption was vesicopustular. Cathelineau (Bull. de la Soc. de Derm. et de Syph., Jan., 1898).

Reports continue to be made to scientific societies of eruptions—*e.g.*, eczema, erysipelas, etc.—produced by the use of hair dyes. The offending constituent, according to published accounts, is the hydrochloride of paraphenyldiamine. Editorial (Gaz. hebdomadaire de médecine et de chirurgie, June 23, 1898).

HYPERTROPHY OF THE HAIR.

SYNONYMS.—Hirsuties; hypertrichosis; polytrichia; trichauxis.

Hypertrophy of the hair may consist either of an abnormal growth or an excessive growth of the hair, as regards either region, degree, age, or sex. Hypertrichosis may be congenital or acquired, and either partial or general in its distribution.

Partial congenital hypertrichosis is not uncommon and is most often present in the form of the hairy mole (*nevus pilosus*) or the warty mother's marks (*nevus verrucosus*). Hypertrichosis over the spine may conceal a spina bifida occulta (Sutton). Hairs in their growth sometimes take an abnormal direction within or without the follicle, especially upon the scalp, eyebrows, and eyelashes; when in the last they turn inward toward the eyeball they produce the affection called *trichiasis*. When hair develops between the eyebrows, or the arms, and on the face of women, forming a mustache or

beard, disfigurement and mental annoyance follow.

Besides the hairy moles cases have been reported in which an isolated, long wisp of hair has been present on the shoulder, scalp, or other part of the body.

[A birth is recalled in which the child had a tuft of dark hair, 2 inches long, situated on a circular base $\frac{1}{2}$ inch in diameter, resembling the switch of a Chinaman. WITHERSTINE.]

General congenital hypertrichosis is a very rare condition; when it occurs there is usually a family history of hairiness. The case of Shwe-Maon, the hairy Burmese and his daughter, Maphoon, is a remarkable instance. The daughter married and had a daughter also hairy. Other cases are recorded, as the renowned dancer Negreni, whose hair increased over three yards in length after recovering from an acute disease; the case of Julia Pastrana, who had a fine beard and a hairy body; Adrian Jęftichjow and his son Fedor (the dog-faced men); Barbara Urster, reported by Stricker, who had a beard reaching her waist. Certain races are noted for hairiness, such as the inhabitants of Jesso and Kurile, islands to the north of Japan.

Acquired hypertrichosis is a milder condition than the congenital and is seldom markedly general in distribution. Wilson reports an unmarried woman aged 33 in whom general hairiness started at puberty and continued until the whole body was covered excepting a bald spot on the top of her head.

During pregnancy a transitory hypertrichosis has been observed, which has disappeared spontaneously after parturition. Jackson reports an instance of this kind in a woman, who after giving birth to several children, suffered from amenorrhea, during which time coarse hair appeared on the face; she became pregnant several years later, and after labor the hairs disappeared.

Partial acquired hypertrichosis in varying degree is seen in some families in adult and in later life. Simple down, or lanugo, develops markedly or a number of coarse, scattered hairs or tufts may be seen on the chin, lips, or other place, resulting in whiskered boys and bearded

women. The case of a boy of 8 years with pubic hairs and a bearded face is reported by Chown. Lesser calls attention to a girl of 6 who started to grow pubic hair at 4, and began to menstruate at 3 years of age.

ETIOLOGY.—Heredity is apparently a causative factor, more marked in dark-complexioned families than in fair. Where hairiness has occurred in women it has been thought that the daughter has inherited the physical characteristics of the paternal line; this appears to have some reasonable basis, as excessive hair growth is frequently met in mannish women. The nervous system has an influence on this condition, insane women being more often the subjects of increased hairiness. Functional and organic diseases of the genitourinary tract, such as amenorrhea, sterility, hypernephroma (see ADRENALS, DISEASES OF THE), have been noted as causes. Dwarfs, monsters, and subjects of spina bifida and congenital deformities are apt to be subjects of this affection. Finally, the use of external irritants (blisters, sinapisms, stimulating lotions, heat) has been followed by increased capillary growth. The popular idea that the growth of hair is promoted by the use of animal fats, glycerin, and petrolatum does not appear to be well founded, though it is efficient in horses.

There is a popular idea among ladies that hair growth is promoted by the frequent employment of an animal fat in a face cream; glycerin and vaselin are also credited with this power of promoting hair growth. These substances by themselves are incapable of promoting hair growth, but the friction employed when using them is productive of hyperemia to the parts, so that possibly, in this way only, the hair roots may be stimulated. On the other hand, in treatment for loss of hair we often find that massage with grease and lotions fails to produce a growth of hair, or even to prevent its loss. Hair growth, therefore, may be promoted by the use of these substances only in these people who have a tendency to excessive hair growth, the resulting hyperemia being the ex-

citing cause. D. Freshwater (Pract., May, 1913).

PROGNOSIS.—Except when due to pregnancy or ill health, the hairy growth is, as a rule, permanent. The facial hair on women generally tends to increase in length, coarseness, and color, more especially at the menopause. As irritated moles may become malignant in nature, the hair on moles should not be removed by plucking or any other treatment likely to give rise to irritation; but removal of the hairs by electrolysis apparently causes the mole to atrophy, leaving but slight pigmentation.

TREATMENT.—The aim should be to destroy existing hair, and to inhibit further growth, or, at least, to lessen the deformity as much as possible. Success is to be looked for only when the growth is slight in extent. It is impossible to arrest the growth, but we may remove or destroy it, if slight. Eight methods of removal may be named, each of which has its special use: **Epilation; shaving, cutting, and singeing; depilatories; hydrogen dioxide; pumice-stone; Kromeyer's method; electrolysis, and X-rays.**

Epilation.—In olden times this was done by applying a pitch plaster and then forcibly tearing it off, bringing the hairs with it. Unna uses a resin pencil, the end slightly warmed, to extract isolated hairs. The use of the tweezers is both ancient and modern. This remedy is inefficient, or at least not permanent, as a new hair soon takes the place of the one, extracted, and, if repeated too frequently, may induce inflammation of the hair-follicles.

Shaving, Cutting, and Singeing.—These also give temporary relief, but their repeated use is unattended with danger. In action they resemble that of the depilatories in that they remove that part of the hair above the level of the skin, and that they must be repeated at intervals. Their use is to be recommended where there is much hair on the face, arms, or legs; although this method may increase the coarseness of the hair, it cannot make new hair grow. Cutting the hair with scissors is tedious. Singeing may be done with the flame of the spirit lamp or a lighted taper.

Depilatories.—These have been employed since ancient times for the re-

moval of hairs. A depilatory is usually some form of sulphide (sodium, arsenic, barium, calcium), which by its chemical action softens and destroys that portion protruding above the skin, as lengthy application would destroy the skin as well. It is usually necessary to repeat the application every three or four days. The particular depilatory used is made in the form of a paste with water, applied with a piece of wood or bone to the affected area, and allowed to remain about ten minutes, when it becomes dry and is quickly removed. The parts are then cleansed with water, dried, anointed with cold cream or sweet oil, and later dusted with carbonate of zinc or magnesium. As the depilatory not only destroys the hair on a level with the skin, but also partially within the follicles, and as no black points or hair-stumps remain, this method is superior to shaving:—

Redwood's formula:—

℞ *Sol. barii sulphuri concentrati*,
Amyli, āā q. s. ad ut ft. pasta.

M.

Duhring's formula:—

℞ *Barii sulphidi* ʒiij (12 Gm.).
Pulv. zinci oxidi,
Amyli āā ʒj (30 Gm.).

M.

The sulphide should be fresh or its action will be unsatisfactory.

Hydrogen Dioxide.—This remedy first bleaches the hair and makes it less apparent, and through continued use the growth of the hair is retarded. In using this it is best to dilute it one-half at first and gradually increase the strength. Bulkley advises the use of this preparation in cases when the hairs are too fine to admit of their removal by electrolysis, especially when they are numerous. The hairs after a time become brittle and break off. This is of special value to brunettes having fine dark down on the upper lip. It may also be used in cream:

℞ *Perhydrol* (Merck) ... ʒiiss (10 Gm.).
Adipis lane anhydrosi.. ʒvj (24 Gm.).

This cream is less rapid in action, does not keep long, but its use is less troublesome.

In all cases where hydrogen dioxide is

used, the skin must be cleansed with ether and alcohol to remove the grease from the hair, which is necessary to permit of the action of the dioxide.

Pumice-stone.—This is a palliative remedy advised by Schwenter-Trachsler. A piece of pumice-stone, without rough edges, is rubbed gently over the affected part against the direction of the hair growth for a few minutes twice a day. The skin should not suffer damage by too hard rubbing, and should receive an inunction of cold cream after each rubbing is over. This is continued for six months. Rest a month and resume for another six months.

The writer has devised a knife in the shape of a small, narrow, rotating cylinder, driven by a pedal or motor. He has found it extremely useful for removal of superfluous hairs. It fits into the skin like a sharp punch, and cut out a long, round plug. Each superfluous hair is punched out separately, leaving a minute, round, deep cavity. The hole is so small that it heals without leaving a perceptible trace. The region is first shaved; then the hairs are stained with henna, which colors the hairs only. The cylindrical knife is inserted slanting, parallel to the course of the hair. The pain is very slight, scarcely more than that of the prick of a needle, but ethyl chloride may be used when wished. Epilation by this means is a simple, rapid process; from 100 to 200 or even 300 hairs can be thus punched out at a single sitting. There is never any recurrence of the hairs if the punched-out plug includes the entire follicle. The cylindrical knives are from 0.7 to 1.2 mm. in diameter. They cut through the cutis into the loose, subcutaneous tissue, so that the plug comes out with the knife or is easily pulled out with pincers. Kromayer (Deut. med. Woch., Bd. xxxi, Nu. 5, 1905).

Electrolysis.—This method is best suited for the removal of coarse, single, or sparsely distributed hairs; where the growth is extensive or the hairs fine and downy this method is inapplicable. As each hair is destroyed singly, the opera-

tion is tedious and tiresome to both operator and patient. Not more than from 10 to 30 hairs can be treated at one sitting. The apparatus needed for the operation is an ordinary galvanic (not faradic) battery of from 6 to 15 cells, electric light street current with rheostat, or 6 large Leclanché cells, 2 electrodes, a sponge being on the positive (3 x 4 inches), and on the negative a fine platinum wire or a fine Cambric needle (No. 12) inserted in a small holder, a dead-beat milliampèremeter, a magnifying lens (or a pair of spectacles of + 1 to 3 D.), and a good broad-blade forceps.

The needle is carefully inserted into the hair-follicle down to the papilla. The patient, holding a moistened sponge electrode (positive pole) by the handle, completes the circuit by bringing the moistened sponge in contact with the palm of the other hand. After five to ten seconds a frothing will be seen at the mouth of the follicle. The current is then broken by the patient removing the sponge from the palm of the hand (releasing the positive pole), and the needle is withdrawn. Upon the slightest traction with the forceps the hair will usually come out; if it does not, the operation must be repeated. At the termination of the sitting, the patient's face should be bathed in hot water and anointed with cold cream; during the day apply some antiseptic evaporating lotion (**calamine lotion** or one of **aluminum acetate**). The wheal-like elevation remaining at the site of operation disappears in a few hours. The following points must be heeded to prevent scarring: The use of a fine needle; avoid too prolonged cauterization and too strong a current; operate on hairs at some distance from one another at the same sitting. A current $\frac{1}{2}$ to 1 milliampère is sufficiently strong; 3 milliampères is the allowable maximum.

The writer uses the platinum-iridium needle with Behrend's needle-holder, in which contact is broken by pressure on a stylet. A current of 2 to 3 milliampères is kept on for twenty to thirty seconds. Warm, moist compresses diminish the inflammatory reaction. While introducing and removing the needle, the

current must be broken, or it causes pain and involuntary muscular contractions. L. Leistikow (Med. News, Nov. 24, 1900).

The essentials for obtaining good results in the writer's operation are: (1) Connect the needle to the negative pole; (2) use a fine stiff wire as a needle (the wire supplied with the finest hypodermic needle is a suitable one), and (3) insulate the wire so that only the last $\frac{1}{16}$ inch supplies the current. The advantages of this method are two: (1) no scarring after the operation, and (2) a lower percentage of regrowth of hairs. Pirie (Lancet, June 19, 1909).

Epilation by the X-rays is too dangerous as yet to be recommended, and the author advises **electrolysis**. If the latter is properly carried out no trace of scar formation or of skin atrophy will remain. In twenty years' experience the author has found the chief source of poor results to be the use of an unnecessarily strong current. He never exceeds 1.5 milliamperes and generally uses only 1 milliamperè for fifteen or twenty seconds even where coarse hair is being treated. If the needle is placed in precisely the right spot, but little current is required to destroy the hair papilla. A frequent source of discouragement to both patient and inexperienced operator is the apparent return of hair in areas already epilated; this represents merely growth from follicles previously temporarily latent, a condition which is of general occurrence after certain of the hairs have spontaneously fallen out. The needles used should be extremely fine and rounded at the end; they need not be of platinum, since they constitute only the negative pole. The circuit should be open when the needle is introduced. There is no certain sign of complete destruction of a papilla at the time of operation; the best guide is loss of adhesion of the hair, which should be readily pulled out after the passage of the current. Dubreuille (Presse méd., Sept. 21, 1912).

X-rays.—Favorable results have been obtained by the use of this form of treatment, but it is not without danger of producing a dermatitis involving serious and permanent changes in the skin (atrophic parchment-like condition, marked pigmentation, and the formation of telangiectases). Schamberg advises the use of the X-rays on facial hypertrichosis only in severe and disfiguring cases in which the extent of the growth makes electrolysis a hopeless task. Walsh uses a combination of X-ray exposure and electrolysis.

Removal of superfluous hair by a combination of **X-ray** exposure and **electrolysis** useful in some cases. The exposure to the focus-tube is made in the ordinary way, and a week or ten days later, when the hair becomes loose, each hair is extracted, and the electrolysis needle passed into the follicles. Sometimes a second exposure is needed before the hairs become loose. The method shortens the period of depilation, but, like electrolysis, it should not be undertaken unless the patient has enough patience to undergo the requisite treatment. David Walsh (Lancet, Nov. 2, 1901).

DISORDERS OF SECRETION. See SEBORRHEA SICCA (DANDRUFF).

SYCOSIS NON-PARASITICA.

SYNONYMS.—Mentagra; folliculitis barbæ; lichen menti; coccogenic folliculitis; sycosis vulgaris.

Sycosis non-parasitica is a non-contagious, inflammatory disease, acute or chronic in its course, involving the hair-follicles, principally of the bearded part of the face or mustache, but occasionally the eyebrows or other parts. It is characterized by the development at once of pustules, papules, and perhaps tubercles, usually perforated with hairs, and accompanied by more or less infiltration. There is suppuration in the hair-follicles, with inflamed skin around them. The disease tends to last indefinitely and sometimes results in scars. Simple sycosis often attacks persons who have never been shaved at a barber's.

TREATMENT.—The employment of both constitutional and local treatment gives the best results.

Internal treatment is best begun with a purge, preferably one of the **mercurials** followed by a **saline cathartic**. The diet should consist of easily digestible and nutritious foods, cheese being strictly prohibited. In the debilitated or those out of health the simple **bitters**, alone or combined with a **mineral acid** and **strychnine**, are useful. In marked debility **massage** and **static electricity** are advised. The combined internal and external use of **phytolacca** has yielded good results. **Iron**, **arsenic**, **phosphorus**, and **codliver oil** are beneficial. The **iodide of iron** in dose of 2 to 3 grains (0.12 to 0.18 Gm.), given in pill three or four times daily, is particularly serviceable. If there is much inflammatory thickening of the parts, Tilbury Fox recommends the use of the **liquor arsenici et hydrargyri iodidi**, 3 to 10 drops thrice daily. If the tendency to pus formation be marked, the **hypophosphites**, **calcium sulphide**, or **potassium chlorate** will do good service.

External or Local Treatment.—The three stages of the disease, suppuration, dermatitis, and constitutional reaction, each demand special measures. In the first stage the hair may be cut short or allowed to remain in the natural condition, providing it will not mask the disease or interfere with the local applications; shaving, says Shoemaker, which is usually recommended, is painful. He has never seen it followed by good results. Remove all scabs and crusts by means of oil-dressings or a poultice. As local applications some prefer lotions, either warm or cold, such as **lead-water** and **laudanum**, weak solutions of **witch-hazel**, **zinc**, or **lead acetate**, or of **bichloride**. Others prefer oily applications, such as oil of **ergot**, olive oil with fluid **oleate of mercury**, or **codliver oil**, alone or combined with **arrowroot**, **zinc**, or **lead carbonate**, **opium**, or **belladonna**, which may be lightly painted over the surface. Among the serviceable ointments at this stage are the **zinc**, **lead**, and **bismuth oleates**, alone or combined with other agents; **calomel** or **white precipitate**, 10 grains (0.65 Gm.) to the ounce (30 Gm.) of **cold cream**, is a valuable preparation. So also is **diachylon ointment** with a few grains of **camphor** added.

In the later stage more stimulating ap-

plications are effective. The ointment of **oleate of mercury** (5 to 20 per cent., according to the condition of the parts) may be applied alone or with other remedies. The ointment of the **nitrate of mercury**, in from 1 to 3 drams (4 to 12 Gm.) to the ounce (30 Gm.) of **zinc ointment**, is useful. **Sulphur**, **tar**, **betanaphthol**, or other antiseptic may be combined with any of the preparations named.

Resorcin, **ichthyol**, **corrosive sublimate**, **salicylic** or **boric acid** may be used. Veill commends a 2 per cent. alcoholic solution of **pyrogallallic acid**, while Pick uses an alcoholic solution of **tar**. Provans's **tragacanth paste** is a soothing, antiseptic application:—

R *Tragacantha* ʒiv (16 Gm.).
Glycerini fʒiv (16 Gm.).
Sodii boratis ʒss (2 Gm.).
Aquæ destillatæ q. s.

M.

Epilation becomes unnecessary if the parts are thoroughly depleted by opening the various lesions with a knife, and puncturing the surface thoroughly, relieving the enlarged and congested blood-vessels, allowing the stagnated blood to circulate, the effused serum to escape, and inhibiting the formation of pus.

The **abstraction of blood** should be resorted to from one to three times a week, the parts bathed with warm water to encourage the bleeding, then mopped dry, and the medication carefully applied on the surface. The incisions and punctures heal rapidly, the induration becomes less, the symptoms disappear, and cure results without scar or deformity. Bockhart advises that the patient should use a face lotion of 1 per cent. **sublimate solution** freely twice a day for some time after active treatment has ended.

The constitutional treatment is both local and general. In the former use an astringent wash (**sulphate of zinc**) upon the skin area; in the general treatment use such as would be appropriate in eczematous conditions.

Local treatment of sycosis must take into account two processes: 1, a suppurative process; 2, a dermatitis remaining after suppuration has been overcome. The first phase

of the treatment consists of cutting the hairs close to the skin and applying antiseptic measures, such as 10 per cent. **resorcin solution**, sprayed on the parts three times daily, and wet dressings of **boric acid solution**, kept in contact with the skin throughout the day and night and renewed five times in the twenty-four hours. Where the hair-follicles show deep suppuration the resulting pustules should be opened, either with an appropriate pointed instrument or by pulling out the central hair. Where the pustules are very numerous, **depilation** of the entire area, either by means of the X-rays or with forceps, is indicated. Antiseptic measures should then be continued until the acute process has subsided; if necessary, depilation may be practised again, three weeks or a month later.

In the succeeding period of simple dermatitis, the following preparations are useful:—

- ℞ *Styrax ointment* 1 part.
Oil of sweet almond ... 2 parts. M.
 Or,
 ℞ *Calomel or turpeth mineral*.. 1 Gm. (15 grains).
Zinc oxide 3 Gm. (45 grains).
Petrolatum 30 Gm. (1 ounce).
 M.

Where these ointments are insufficient, various agents used in eczema, such as tar, oil of cade, salicylic acid, etc., may be tried. Thus:—

- ℞ *Salicylic acid* . 0.5 Gm. (7½ grains).
Resorcinol 1 Gm. (15 grains).
Oil of cade ... 5 Gm. (1¼ drams).
Zinc oxide ... 10 Gm. (2½ drams).
Petrolatum ... 30 Gm. (1 ounce).

M. et ft. ung.

Sulphur preparations, too irritating in acute forms, may be used in the more sluggish cases:—

- ℞ *Precipitated sulphur* 1 to 3 Gm. (15 to 45 grains).
Tannic acid .. 1 Gm. (15 grains).
Zinc oxide .. 2 Gm. (30 grains).
Petrolatum ... 30 Gm. (1 ounce).

M. et ft. ung.

In altogether chronic cases, with thickening and induration of the skin, linear scarifications may be resorted to. Sabatié (*Progrès méd.*, Dec. 23, 1911).

PARASITIC DISORDERS.—TINEA FAVOSA.

SYNONYMS.—Favus; porrigo favosa; dermatomycosis favosa; Erbgrind (G.); crusted ringworm; honeycomb ringworm.

Tinea favosa is a contagious vegetable parasitic disease produced by the *Achorion Schönleini*. It is characterized by the formation of small, round or oval, cup-shaped, pale-yellow, brittle crusts, which are usually situated over the hair-follicles, and are perforated by hairs. The name favus—a honeycomb—was suggested by their resemblance to a honeycomb.

TREATMENT.—Patients who are debilitated and those of syphilitic or scrofulous diathesis should receive internal treatment suited to them. **Codliver oil** and **syrup of the iodide of iron**, with good, **nourishing food, fresh air, and healthful exercise**, are indicated.

Thorough and persistent local treatment is necessary if we would destroy the parasite. The first indication is the **removal of the crusts**; the second, the use of an antiparasitic to destroy the fungus on the surface as well as in the hairs and hair-follicles. The best means for removing firm crusts is by saturating them, for twenty-four hours, with oils, of which the **oil of ergot** will be found the most effective. Olive, almond, and phenolized oils are not so suitable. Poultices are not only unpleasant, but injurious, as they increase the growth through their heat and moisture, and increase the swelling of the epidermis to such an extent that the use of the antiparasitics is interfered with. Warm dressings and bandages produce the same effects. The German soap-spirit acts destructively on the skin. An antiparasitic lotion which is detergent, antiseptic, and softens the crusts is a 25 or 50 per cent. solution of **boroglyceride**, sponged thoroughly over the affected area, after the crusts have been covered with **oil of ergot** for twenty-four hours. In one or two hours the crusts will easily peel off, and the skin will be clear and clean, ready for one of the potent anti-

parasitics. Shoemaker prefers the **naphtholized zinc oleate ointment**. The hair and skin are first well dried, and after a few hours the antiparasitic is freely applied over the affected surface, the best being the **oleates of mercury** and of **copper**, the definite chemical compounds, not the solution of the oxides in oleic acid. He prescribes them as follows:—

℞ *Ung. hydrargyri oleatis*,
Adipisāā ʒiv (16 Gm.).

℞ *Cupri oleatis* ʒss (2 Gm.).
Adipis ʒj (30 Gm.).

M.

A little of the former ointment is first well rubbed in with the finger-tips, and after a few days alternated with the latter, which is astringent and relieves any irritation set up by the former. These applications should be made every day or two, and continued for three or four weeks. If after cessation of treatment for a week or two the hair does not assume its natural aspect, and new favus crusts develop, the treatment should be renewed. After the crusts have been removed, the use of water, for any reason, is prohibited. A single hair extracted from each of the diseased spots will show when treatment has been sufficient. Other efficient remedies are **resorcin ointment**, a 10 per cent. ointment of boric acid, **chrysarobin**, **thymol iodide**, and **euophen**.

Schamberg advises that the diseased hairs be first **depilated** and then **parasiticide ointments** and lotions used. Sabouraud has successfully used the **Röntgen rays** in favus. The difficult technique is the main objection to its use.

TINEA TRICHOPHYTINA.

SYNONYMS.—Ringworm; *tinea sycosis*; *sycosis parasitica*.

This is a contagious parasitic disease affecting the hair and the hair-follicles, as well as the nails and epidermis, being caused by a microscopic vegetable fungus known as the *trichophyton*. It is characterized by the formation of circular erythematous or grayish scaly patches, vesicles, and tubercles, upon which the hairs are ragged, broken, or destroyed. When the scalp is attacked the disease is known as *tinea tonsurans* or *tinea trichophytina capitis*; when the beard is affected

it is called *tinea sycosis* or *tinea trichophytina barbæ*; when the nails are affected it is known as *onychomycosis* or *tinea trichophytina unguium*; when on the body it is known as *tinea circinata* or *tinea trichophytina corporis*.

TREATMENT.—Schamberg recommends daily **soap** and **hot water** cleansings of the scalp with **tar**, **phenol**, or **sublimite soaps**; **depilation** of diseased hairs and of those surrounding the affected areas, and, finally, the use of **parasiticide ointments** and lotions. The keynote of success is the thorough and persevering use of the preparation that gives a successful result. **Ointments of betanaphthol** or of **iodine** (1 in 8); of **chrysarobin** (1 or 2 in 24); of **sulphur** or of **tar** (1 or 2 in 8); of **phenol** (1 in 20). He especially recommends brushing into the patches several times a day the following:—

℞ *Olei cadini*,
Olei olivæāā fʒj (30 Gm.).

M.

In the morning a **carbolic soap** is used with hot water. The following also yields good results:—

℞ *Sulphuris præcipitati*,
Betanaphtholiāā ʒj (4 Gm.).
Petrolati ʒj (30 Gm.).

M.

Croton oil, **chrysarobin**, and **pyrogallie acid** have been used with the idea of producing follicular suppuration and thus hastening the cure.

The **X-ray** treatment of *tinea tonsurans* has been developed to that point, by Sabouraud, that he often cures a patch in one treatment. The dosage is measured by the effects of the rays upon discs charged with barium platinocyanide, which changes in color. He insists that the dose be carefully measured. The treatments are given at a distance of 15 cm.; the discs are fixed midway between the patient and the source of the rays. From ten to fifteen minutes' exposure is usually sufficient. He prefers a large static machine and tubes of small diameter and of high vacuum. After from eighteen to thirty-five days the hairs fall. After the exposure the head is painted every day with a 10 per cent. **tincture of iodine**; daily **soap** and **water washings** are used

after the eighteenth day. Restoration of the hair begins after two months, the affected areas being bald in the mean time.

PEDICULOSIS.

SYNONYMS.—Phthiriasis; lousiness: Läusesucht (G.); pou (F.).

This is a contagious disease caused by animal parasites called pediculi, or lice, which attack the skin and with the exception of the body-louse live and propagate in the hairy portions of the body. When domiciled in the head, it is known as *pediculus capitis*; when in the hair of the genitalia, it is called *pediculus pubis*; a third variety, infesting the clothing, along the seams, is known as *pediculus corporis* or *vestimenti* (body- or clothes- louse). The latter caused trouble during the great war.

On the head *pediculi capitis* are found mostly in the occipital region and when present eggs or nits are to be found, which appear as small, opaque, white, globular bodies, attached closely to the hair-shaft by a glue-like substance, usually near the hair-roots in recent cases, but in old cases near the extremities of the hairs. In neglected and chronic cases the head, with its dirty, matted, twisted, and glued-together hairs, filled with decomposed pus, crusts, lice, and nits, presents a condition known as "*plica polonica*."

The *pediculus pubis*, or crab louse, the smallest of the three lives in the pubic region, and at times the eyebrows, eyelashes, beard, mons veneris, axillæ, and the sternal region, thighs, abdomen, and scrotum, if supplied with hair.

TREATMENT.—The indications are to destroy the lice and their ova (nits), and to restore the skin to its normal condition. For the former purpose we may use **betanaphthol**, the **mercurials**, **tobacco**, **cocculus indicus**, **staphisagria**, **sabadilla**, **phenol**, and **sulphur**, in powder, lotions, infusions, ointments, and in the form of soaps. **Crude petroleum**, or **kerosene** alone or mixed with **sweet oil**, is efficient. The nits may be destroyed by solutions of **soda** or of **borax**, **vinegar**, dilute **acetic acid**, and **alcohol**.

NEUROTIC DISORDERS.—TRICHOPATHOBIA.

Under this name is included all cases of mental worry about the hair, on account

of its loss, its color or change of color, and its excessive or misplaced growth. The loss of hair is most often a cause of worry, to women; in men, rarely, except in those who are syphilitic. Worry on account of the color of hair is unusual except that certain shades of red may give rise to distress. Worry over the graying of the hair sometimes drives women to the use of hair-dyes, to their harm. Worry over superfluous hairy growths is the most serious form of trichopathophobia; insanity not infrequently develops from this, especially in neuropathic women. Mewborn suggests that perverted or arrested activity of the sexual functions may be an etiological factor in this condition, and that there is good evidence of the influence of ovarian secretion on the growth of hair.

VOLUNTARY ERECTION OF THE HAIR.

Violent emotion and the reflex action of cold are known to produce goose-flesh (*cutis anserina*), which is merely a bulging of the hair-follicles, and an erection of the hairs, through the contraction of the arrectores pilorum muscles, which are attached to the hair-follicles. Voluntary erection of the hair is rare, but Maxwell reports a case.

Case of a young man who could produce bulging of the hair-follicles and erection of the hair at will. This condition was best seen on the hips, thighs, back, and arms. Associated with this condition was a remarkable development of the dermal structures. The subject had an unusual control of the facial muscles: he could move the skin of his scalp freely in various directions; he could move his ears simultaneously, alternately, or singly at will. His powers were not the result of practice, but were apparently inherited from his father, who possessed them to a considerable degree. It seems that in the lower animals a high development of the panniculus structures and the power of erection of the hair go together. The subject experienced modifications of the respiratory movements whenever he in-

duced the phenomenon. He felt as if the chest was held rather more than usual in the inspiratory phase and the breathing deepened or was momentarily suspended. Erection of the hairs was also accompanied by sensations of pleasure, and afforded feelings of relief, especially when the patient suffered from headache. The erection of the papules was accompanied by vasomotor changes shown by a contraction in volume of the finger. Dilatation of the pupil also accompanied it. A biopsy was performed on the subject to determine whether the arrectores pilorum contain striated muscle or not. Only smooth muscle was found. Here was an example of smooth muscle being voluntary at the same time. The old distinction between striated, or voluntary, and unstriated, or involuntary, muscle can no longer hold. The difference between muscles must rather depend on the manner and rate of contraction. S. S. Maxwell (Amer. Jour. of Physiol., July 1, 1902). W.

HAMAMELIS.—Hamamelis, or witchhazel, consists of the bark, twigs, and leaves of *Hamamelis virginiana*, a North American shrub growing east of the Mississippi River.

The leaves, collected in the autumn when the twigs are flowering, have an odor resembling that of tea and an astringent, bitter taste. They contain about 10 per cent. of tannin, bitter and odorous extractives, and a trace of oil.

PREPARATIONS AND DOSES.—

Hamamelidis cortex, U. S. P. VIII (witchhazel bark and twigs); dose, 30 gr. (2 Gm.).

Hamamelidis folia, N. F. (witchhazel leaves); dose, 30 grains (2 Gm.).

Fluidextractum hamamelidis foliorum, U. S. P. (fluidextract of hamamelis leaves); dose, 30 minims (2 c.c.).

Aqua hamamelidis, U. S. P. (witchhazel water); dose, 2 drams (8 c.c.). The best preparation for external application. It is prepared by distilling the leaves and twigs with water and the addition of 15 per cent. (vol.) of grain alcohol. Usually known as extract of witchhazel.

THERAPEUTICS.—Hamamelis is hemostatic, astringent, and tonic in its action. Containing considerable tannin, it coagulates the albuminous elements of the tissues, when applied locally, and diminishes the blood-supply and secretions.

In Hemorrhage.—The fluidextract has been given internally for the relief of **pulmonary, renal, and uterine hemorrhage; purpura, hematemesis, varicose veins and hemorrhoids.**

The local application of hamamelis has likewise been used for recent **wounds, sprains, bruises, superficial hemorrhage, hemorrhoids, epistaxis**, and for bleedings or discharges from the natural cavities or openings of the body.

Hamamelis is exceedingly useful in **capillary hemorrhage**. In cases of **intermenstrual oozing**, where the endometrium is lax and congested, if fluidextract of hamamelis be swabbed over the entire inner surface the oozing will cease, and if repeated every few days it will become healthy. Many cases which were formerly subjected to curettement may be rendered perfectly well if this is faithfully followed up.

Sore and bleeding gums, relaxed uvula, and oral ulcers will heal if the following is used every two or three hours:—

R *Aquæ hamamelidis*,

Aquæ rosæ āā ʒvj (180 c.c.).

It possesses marked sedative properties, and patients will often cease to complain of pain in a **sprained joint** or congested area after a compress of hamamelis has been applied. The distilled extract makes a very nice application for **burns and herpetic eruptions**. H. R. Caston (Therap. Gaz.; Med. Bulletin, Feb., 1907).

As an Astringent.—Hamamelis is used, in diluted form as a **mouth-wash**, as a gargle in **chronic pharyngitis**, and in spray after attacks of **acute coryza** (1 part to 8, or 1 part to 24).

In relaxed conditions of the mucous membranes generally hamamelis is beneficial. Peristalsis and the secretions of **enteritis** are checked. It is of value in **diarrhea and dysentery**. S.

HAMMER TOE. See ORTHOPEDIC SURGERY.

HAND, CLUB-. See ORTHOPEDIC SURGERY.

HANOT'S CIRRHOSIS. See CIRRHOSIS OF THE LIVER.

HARELIP. See SURG. ANAPLASTY.

HASHISH. See CANNABIS INDICA.

HAY FEVER. See HYPERESTHETIC RHINITIS.

HEAD AND BRAIN, DISEASES OF.

DISEASES OF THE SCALP.

CONTUSIONS.—These are commonly the result of blows or falls, which leave the patient more or less stunned, and cause an effusion of blood into the tissues, which may amount to a hematoma. Localized swelling occurs at the point of impact, which is due to hemorrhage and effusion under the scalp, the latter being raised up into a soft, semi-fluctuating tumor, the edges of which are regular, pit on pressure (sometimes with moist crepitation), feel hard, and are usually above the contour of the head, while the center feels soft. In some cases this extravasation simulates a depressed fracture of the skull, especially in children, and this deceptive feeling will occur without any considerable extravasation of blood beneath the scalp, the depressed center being due to the compression of the scalp by the blow that has inflicted it (Erichsen). In case of doubt it will be safer to make an incision so as to examine the state of the bone, but usually the smooth bone can be felt at the bottom of the soft central depression.

Treatment.—The treatment of contusion of the scalp is very simple.

The use of some evaporating lotion, or **lead-water** and **laudanum**, with **slight pressure** is usually sufficient. Under no circumstances should the swelling be punctured or the blood let out in any other way. Erichsen has found contusion of the scalp in girls and young women in some cases to be followed by severe neuralgic pains in the part struck. In such cases **incisions** down to the bone have been followed by improvement. See also **WOUNDS OF SCALP**.

The treatment of the various forms of injury is well described by Lawrence as follows: Contusions of the scalp caused by slight blows or falls, and accompanied by a moderate amount of effusion, are simple and require little treatment. Contusions of the scalp caused by sharp blows or severe falls are always to be examined carefully, and a guarded prognosis given. Those accompanied by large effusions, and especially if pulsating, should be treated by **shaving the scalp, incising, and turning out clots** (examining carefully the pericranium and skull), securing bleeding points, closing with **sutures**, preferably braided silk, and dressing with dry **antiseptic dressing**, which should only be removed when absolutely necessary, before the fourth or fifth day, when the sutures should be removed, and a light compress **bandage** applied. Those accompanied by little or no swelling, when caused by severe blows, should be carefully watched, and, on the first appearance of local fever or swelling, should be **freely incised, washed out**, and treated as open wounds. If the case is not seen until the patient has had chills; hot, dry skin; hard pulse, fever-coated tongue, nausea or vomiting,

insomnia, nervous twitchings, or any other symptoms of meningeal inflammation, we should cut down and **trephine** at once over site of injury. While inflammation of either pericranium or the meninges is one of the things likely to follow these injuries, it may be prevented by early **incision**. Where caries of bone or meninges occurs, the cause may generally be found to be injury of the pericranium, which becomes inflamed; effusion follows thereupon, then inflammation of the vessels from pressure, and then, by extension, meningitis.

WOUNDS OF THE SCALP.—

These are of common occurrence, and are more serious than similar injuries located elsewhere, especially in persons of vitiated or impaired constitution. These injuries are more likely to be followed by erysipelas, and have a great tendency to the propagation of inflammatory action inward to the brain, which latter gives a serious or even fatal aspect to comparatively slight lesions. It must not be forgotten, however, that the blow or fall which occasions the scalp wound may cause fracture of the skull, or produce concussion or even laceration of the brain.

Insofar as injuries of the tissues of the scalp are concerned, there is little danger, for they are freely supplied with blood and endowed with great vitality, so that repair is favored and sloughing seldom occurs even when the tissues are severely contused and extensively lacerated, the existence of a slight pedicle of attachment sufficing to insure the vitality of a large flap. It is, therefore, important to save all portions of the lacerated tissue unless entirely detached.

Treatment.—In all wounds except very small ones the head should be carefully examined for fracture of the skull or, in the absence of this, for signs of concussion or intracranial hemorrhage. The **scalp** should be **shaved** over a wide area, to insure thorough cleansing and disinfection. All dirt and foreign matters should be removed by **rubbing the surface with olive oil, washing well with Castile soap** and warm water, and finally scrubbing the surface thoroughly with a solution of **bichloride of mercury** (1:1000). If the wound be a simple cut, it will often suffice to bring the edges together with a strip or two of **adhesive plaster**; it is generally better to bring the edges together and secure them accurately with **sutures**. A generous **sublimate dressing** should be applied and retained by a recurrent **head bandage**.

Though the scalp be bruised, lacerated, and begrimed with dirt, as well as wounded, or a larger or smaller flap be separated from the bone, none should be cut away; but after shaving the head and arresting hemorrhage by ligature or compression, it should be cleansed and disinfected thoroughly and the parts replaced in their proper positions. Usually drainage will be required until granulations have formed, to insure against retention of pus.

History of 26 cases of scalp avulsion, including a personal one. The outcome is not known in 2, but 20 patients recovered. The defect was covered with **Thiersch flaps**, and in the case reported the flaps healed so perfectly in place that there is no cicatricial retraction, although the defect extended to the back of the neck. The main points in treatment are to protect the flaps against pressure and the wound from infection. Attempts

to apply flaps taken from the scalp proved only partially successful, as only a few of the flaps—prepared according to the Wolfe-Krause technique—healed in place. The rest of the defect was covered with Thiersch flaps from the thighs, five different sittings being required for this Thiersch flap transplantation. Enz (*Correspondenzbl. f. schweizer Aerzte*, Bd. xxxv, Nu. 21-22, 1907).

Case of a young woman from the top of whose head a portion of the scalp $6\frac{3}{4}$ by $7\frac{3}{4}$ inches, was torn. It was placed in **normal salt solution** after thorough cleansing, the hair shaved, the edges trimmed, the scalp sewed on, using a continuous suture, and a gauze dressing applied. On the third day, the center seemed dead and was dissected off, and the wound dressed with a solution of **chlorinated soda**, 1 dram (4 c.c.) to the pint (500 c.c.). At the end of one week only a strip of tissue, $\frac{1}{2}$ inch wide, extending halfway round the scalp, was left. The cranial bones were kept covered with petrolatum and the scalp dressed with compresses of normal salt solution. Granulations appeared, and by the fifth week covered the greater part of the vault; **skin grafting** was then commenced (Thiersch's method) and continued every day for eight weeks. Lawrence (*Jour. A. M. A.*, June 17, 1911).

In extensive scalp wounds in which a portion of the cranial surface is entirely exposed, there is no tendency to granulation over the bone, and grafts will not take hold. In order to excite granulation over the cranium, one need but drill a few small holes in the external table to set free the connective tissue of the diploe. From 10 to 50 such holes may be made about 1 centimeter apart. Under a normal saline solution compress renewed every 2 or 3 days, reddish islets of granulation tissue appear through the holes and extend over the bony surface. In a few weeks the bone is covered, and **epidermal grafts** can be successfully applied. J. Labouré (*Presse méd.*, June 14, 1917).

TRAUMATIC OR SPURIOUS MENINGOCELE.—This is a collection of cerebrospinal fluid beneath the scalp following a fracture. It is usually found in children. The tumor pulsates, transmits an impulse on coughing, and may be reducible. The treatment consists of **excision** of the **sac** and **closure** of the **opening** in the membranes.

ABSCCESS OF THE SCALP.—Abscess of the scalp may follow erysipelatos inflammation, contusions, infection from the exterior, disease of the cranial bones, or the imperfect disinfection and careless dressing of wounds of the scalp.

The symptoms of abscess are an erysipelatos condition of the scalp, accompanied with pain and usually marked edema and pitting on pressure. There is usually some fever, at times intense and often accompanied with delirium. There is great danger from the burrowing of the pus; if it burrow beneath the pericranium, and sometimes if more superficial, there is danger that the inflammation may extend inward to the brain through the vascular openings in the skull and cause meningitis.

Treatment.—Free incision should be made, as soon as the abscess is discovered, at the most dependent point. **Disinfection** of the wound and **drainage** should be followed by **antiseptic dressings** and **drainage**.

CAPUT SUCCEDANEUM.—During the birth of a child extravasation of blood and serum not infrequently occurs in that part of the scalp which presents, as a result of the passive congestion. The extravasation varies in degree according to the duration of labor and the severity of the pains. This swelling is called caput suc-

cedaneum. The seat of this extravasation is in the loose connective tissue external to the pericranium. The tumor is usually situated over the occipital or parietal bones near the posterior fontanelle, and is soft and painless.

This condition seldom requires treatment, as it gradually diminishes in size and finally disappears in a few days or weeks.

TUMORS.—A common form is the *sebaceous tumor*, or *wen*. Varying in size from that of a pin's head to an orange, occurring singly or multiple, of slow growth, smooth, round or oval in shape, movable beneath the integument, they are familiar objects. They are readily diagnosed from fatty tumors by their firmer consistence and smoother surface; evacuation and examination of contents will remove any doubt. The sebaceous cyst is distinguished from abscess by its slow growth, history, situation, mobility, and elasticity; the existence of the dilated opening of the sebaceous duct and the expression and examination of some of its contents will confirm the diagnosis.

Treatment.—**Extirpation** is indicated. After cleansing the hair and scalp the hair is evenly parted over the tumor, an incision made down to the sac, and the tumor enucleated. To prevent return, the sac should be entirely removed. Hutchinson reports a case in which an aggregation of small sebaceous tumors of the scalp became malignant in character. He, however, remarked the rarity of such disposition in sebaceous tumors.

Horns.—If let alone, it occasionally happens that the sebaceous matter exudes through the sebaceous duct, and forms a scab or crust,

which by a process of subdeposition becomes conical; and being gradually pushed up from below, and assuming a dark-brown color by exposure, it forms an excrescence that resembles a horn. **Surgical removal** is indicated.

Warts and Moles.—Warts and moles are cutaneous hypertrophies. Warts when non-irritating and small require no attention, but, if they show a tendency to grow, they should be removed by the knife, as they sometimes display a malignant character. Moles are of two kinds: the hairy and the pigmented. Treatment is by **surgical removal** under **cocaine anesthesia**. A subsequent **plastic operation** or **transplantation of skin** may be necessary to cover over the denuded surface.

Fatty Tumors.—Fatty tumors are rarely met with in the scalp. They resemble somewhat the sebaceous cyst, but are flatter, less globular, and more deeply seated. The treatment is similar to that of the sebaceous cyst: **extirpation**.

Congenital Cysts, Fibromata.—Congenital cysts (sebaceous and dermoid), fibromata, are occasionally found in the scalp. They are easily recognized and removed.

VASCULAR GROWTHS.—See, also BLOOD-VESSELS, TUMORS OF. **Capillary Varix, Nevus, Erectile Tumor, Vascular Growth, or Mother's Mark.**—Of these, two varieties are noted, depending upon the size of the capillary vessels which make up the tumor. When the capillary vessels are large, they usually form a *raspberry-like tumor*, at first small in size and somewhat elevated above the skin. Their tendency, if let alone, is to increase steadily in size, the capil-

lary walls becoming thinner, until danger from serious hemorrhage threatens. This variety should be removed early, especially if the tumor shows any tendency to grow in size or to extend laterally. If small, the tumors may be removed by **excision** or **ligature**, the base in the latter procedure being transfixed by a harelip-pin and the ligature passed beneath it before tying. If larger, two pins may be inserted at right angles to each other, or a double ligature may be passed around a single pin; the larger tumors are best ligated in sections. In any case care must be taken to insure the removal of the entire tumor.

The *port-wine mark* is composed of small capillary vessels; extends over more or less surface, and exhibits little or no tendency to spread. It is more unsightly than dangerous. It is best removed by **excision**, if not too large, making the incisions so that a linear scar only shall remain. A small portion of the mark may be frozen, the surface cross-hatched with a fine knife, and the hemorrhage arrested by firm pressure with sterilized blotting-paper. This process, repeated until the whole surface of the tumor has been treated, is practically painless and leaves no appreciable scar. The cautery and escharotics have been used with success, but are not to be advised, on account of the unsightly scars which are left.

DISEASES OF THE SKULL.—

For FRACTURES OF THE BONES OF THE SKULL, see FRACTURES. For NON-PENETRATING WOUNDS OF THE SKULL, see CEREBRAL CONCUSSION and WOUNDS OF THE BRAIN, this article.

PENETRATING WOUNDS OF THE SKULL AND BRAIN.—These

are produced by severe blows or falls; by kicks; by the penetration of knives, swords, bayonets, rifle balls, etc.; by sharp spicula of depressed fractures, and by *contrecoup* with or without fracture. These wounds may be received on sides or vault of the cranium or through the mouth, nose, or orbit. These wounds are usually accompanied by fracture of the skull: in many cases punctured fractures of most dangerous character. They are all more or less septic in character, with laceration of the brain substance, the deposition of foreign bodies (fragments of bone, hair, clothing, bullets, etc.), more or less severe hemorrhage, and in many cases with loss of brain substance. More rarely—as in children—the wound may be received through the fontanelle, or in adults through a large parietal opening without accompanying fracture.

Symptoms and Diagnosis.—The symptoms and results of the wound vary according to the age of the patient, seat and extent of the injury, septic conditions of the weapon and wound, etc. In some cases the symptoms are very slight and much delayed, but more often are severe and promptly manifested, and are proportionate to the extent of the injury.

If the injury be moderate, headache occurs, with all the symptoms of encephalitis in course, followed by coma and death if not soon relieved. The most valuable symptoms tending toward such relief are the localizing symptoms, which may often reveal a hidden injury. If the injury involves the structures at the base of the brain governing the respiratory act, immediate death must ensue. If the anterior lobes and upper parts of the

hemispheres be injured, but slight symptoms may occur. Twitching of the muscles and epileptiform fits are symptoms of cerebral laceration, and these complicating stertor or alternating with it make the diagnosis clear.

In those cases in which no external wound exists we may suspect laceration if we find that the ordinary signs of compression or concussion are associated with symptoms that do not ordinarily present themselves in these conditions when uncomplicated, such as contraction of one pupil, dilatation of the other, or an alternation of these states with convulsive twitchings of the limbs, hemiplegia of one side, or paralysis of one arm and the opposite leg, with perhaps involuntary spasmodic movements of the other members. In laceration of the brain without compression the pupils are contracted. When laceration and compression are both present, one pupil may be dilated and the other contracted; or both will be dilated or contracted according to the predominance of the symptoms of compression or of laceration. These irregular symptoms, accompanied by much coldness of the surfaces, slow pulse, and depression of vital power, indicate cerebral laceration. Paralysis due to a cerebral lesion is always manifested on the opposite side of the body, but not necessarily opposite to that on which the blow was received, as the injury may be from *contrecoup*.

Glycosuria is an occasional consequence of injury to the brain, and the location is usually referred to the central part of the medulla oblongata and the floor of the fourth ventricle. Blindness may result from in-

jury to the optic nerves at any part; ptosis and strabismus result from injury to the third, fourth, or sixth nerve. The seventh nerve most frequently suffers, being not uncommonly torn across in fractures of the petrous portion of the temporal bone, either in its facial or auditory portion, producing either facial paralysis or deafness. Injury to the eighth nerve is rare, and patients rarely survive who give evidence of the lesion. Motor aphasia points to a wound above and in front of left ear; word-blindness, or apraxia, points to an injury above and behind the ear; hemianopsia indicates a wound of the cuneus; paralysis of face, arm, or leg would point to their respective cortical centers as the seat of injury.

Prognosis.—The danger of wounds of the brain is greatest and most immediate in injuries of the base, of the pons, and of the crura cerebri; it is least and most remote when the seat of the lesion is in the upper and anterior part of the hemispheres, in some cases there being no positive indication of any injury when so located. Unless the pons or medulla have been wounded, the patient seldom dies at once. Children often bear extensive injuries to the brain, and even considerable loss of brain substance, without immediate or remote effects of serious nature. As a general rule, the younger the patient, the greater the chance of recovery. The prognosis is usually more favorable in men of the laboring classes.

Treatment.—In these injuries to the brain the **head** should be clean **shaved**, and the **parts** thoroughly **washed, scrubbed, and cleansed** with an **antiseptic solution**. All foreign bodies on the outside should be

washed away or removed with forceps. Foreign bodies, fragments of bone, etc., which have entered the brain should be removed and the depressed bone elevated. **Disinfection** of the **brain cavity** and arrest of hemorrhage by **pressure, hot water, or ligature** should follow. The dura should be **sutured**, if not too much lacerated, missing portions being covered in by a portion of the pericranium. The wound should be **drained**, rubber tubing being preferable, the flaps of scalp replaced and **sutured**, and a generous **antiseptic dressing** applied. If secondary abscess appears, and it should be carefully watched for, the **pus** should be **evacuated** as soon as detected.

Observations on 106 cases of cranial injuries led the writer to conclude that under good conditions every case of fractured skull should be operated on within 3 days after admission. If received after 14 days it is probably best not to operate unless there be definite clinical manifestations of increasing intracranial mischief. Meanwhile certain conditions may demand immediate operation: active septic processes in a badly drained wound; evidence of cerebral irritation or compression; coma and slow pulse. R. Whitaker (*Brit. Jour. Surg.*, iii, 708, 1916).

Severe complications may follow apparently insignificant injuries of the head by small shell fragments. In cases of small head injuries which manifest mild or severe bone or brain disturbances after apparently healing, even several weeks after the wound, no time should be lost, but the bone and dura at once explored. In fact, it seems advisable to inspect the skull, if necessary enlarging the scalp opening with the knife, immediately after even the mildest scalp wounds. A. Martin (*Paris méd.*, Dec. 9, 1916).

A study of 152 cases of cranial and craniocerebral wounds reported

by different authors by the writer, showed that 60 per cent. were in the parietotemporal region; 22 per cent. in the frontal region; 18 per cent. in the occipital region. In 130 cases there was a complete fracture of the skull and in 85 of these the dura mater was involved. On the whole, the prognosis of cranial injuries by gunshot is grave and varies not only with the intensity but also with the site of the lesion. Thus temporal lesions are the most severe; parietal and frontal come next, while occipital wounds recover in practically every instance. H. Hartman (*Bull. et mém. Soc. de chir. de Paris*, lxii, 1263, 1916).

GUNSHOT WOUNDS OF THE HEAD.—These injuries may involve the integrity of the scalp, the skull, or the brain. The serious nature of these lesions is not always appreciable at first sight. A glancing shot may have injured apparently the scalp alone, while in reality the skull may have suffered such injury that necrosis of the bone will follow, fracture of the internal table, perhaps with splintering or depression; or even the brain and its membranes may be at once or later involved. In these injuries the scalp often sloughs extensively, the tissues being devitalized by the "energy" of the ball; perforation or deep penetration is not the only means by which the energy of a projectile is measured, for its disruptive, tissue-destroying powers are of equal importance. In other, more serious cases extensive injuries of the brain and skull may result. Tillmanns has shown by experiments on animals that a bullet in its passage through the brain does not leave a smooth track, but that it leaves, behind it, tears which radiate out from it. The gray substance is usually



Gunshot wound of the brain.

more torn than the white; this suggests that the latter is firmer.

When gunshot wounds involve the brain they may be either perforating or penetrating; perforating, when the missile passes entirely through the head, and penetrating when the missile enters the brain, but does not emerge. The severity of the injury to brain or skull varies within very wide limits. The wound of exit is always larger than that of entrance; this difference is more marked in the skull than in the soft parts. In a perforating wound of the skull the wound of entrance in the external table may be very small, while the inner table may be severely fractured; at the wound of exit the outer table usually suffers most, and the entire opening will be much larger than the wound of entrance. Besides the presence of the missile, there may be fragments of hair, bone, etc., present along the tract of the wound, and more or less hemorrhage and infection, as explained in WOUNDS OF THE BRAIN.

The symptoms are similar to those given under WOUNDS OF THE BRAIN and FRACTURES. Localizing symptoms, however, may be absent more or less completely, owing to the far-reaching effects of this class of injuries.

At the battle of Mukden, the mortality from penetrating wounds of the skull and brain made by bullets of small caliber was 32.34 per cent., and that from similar wounds inflicted by artillery shells 55 per cent., both remarkably low from the ordinary view of the deadly nature of penetrating wounds of the brain. Matignon (*Presse méd.*, March 9, 1907).

The writers report the results of gunshot wounds of the head in 1239 cases in 8 hospitals. The mortality

was 3.7 per cent. In 22 post-mortem examinations, it was found that nearly all had died of septic infection. No death occurred when the dura remained uninjured. But 8 cases of insanity or epilepsy followed. Dullness, loss of memory, irritability, and childishness tended to disappear or diminish with time. Jacksonian epilepsy was surprisingly rare. Sargeant and Holmes (*Journal of the Royal Army Medical Corps*, Sept., 1916).

Results obtained by the writer in 51 gunshot wounds of the head showed the advantage of early intervention.

Rapid transit and advanced surgical posts for treatment of head injuries are the best means of checking the mortality from such injuries. Fasiani (*Giornale della reale Accademia di medicina di Torino*, lxxix, 278, 1916).

Treatment.—In many cases rigid protection of the wound against infection may render further interference unnecessary. Balls and bullets often become encysted. If operation be determined upon, the entire scalp should be **shaved** and **disinfected** (see TECHNIQUE OF INTRACRANIAL SURGERY in this article). If any serious hemorrhage be present, the wound of entrance or the wound of exit or both must be freely enlarged with the rongeur forceps or the trephine, and the vessels secured by **ligature**, by **pressure**, or with **hemostatic forceps**. The bullet or missile must be **removed** if possible, a counteropening being made, if necessary, for this purpose. Secure free **drainage**; if need be, by a counteropening; the drainage-tube may, for this purpose, have to traverse the entire brain. **Antiseptic dressings** should be applied, and treatment continued upon the general principles involved in cerebral surgery. The

above line of treatment is that advised by Keen, briefly stated. Several devices have been introduced to facilitate the finding of the bullet, etc. Girdner's "telephone probe" is an ingenious instrument in which one end of the probe is attached to a telephone receiver which may be fastened to the ear. If the probe touches the ball, it will indicate it by a grat-

(E). The probe is allowed to gravitate along the track of the bullet until it is arrested; the groove of the trajector is then applied to the probe, and the movable rod on the other end is moved in until it comes in contact with the skull (F). This will represent the point where the bullet impinged upon the skull opposite the point of entrance, in case it has



Morgan's trajector.
(Indiana Medical Journal.)

ing sound. If the ball is not over $2\frac{1}{4}$ inches from the surface, Girdner's "induction balance" may also indicate its location, and the counteropening may be made close to the ball.

Morgan, of Indianapolis, has devised what he calls a "trajector" for determining the course of a bullet in gunshot wounds of the skull. It is composed of a solid steel bow (A) in the end of which is a movable rod (BF). The opposite end of the bow is supplied with a triangular groove (C) on its under surface, so that it will adjust itself to the searching probe

passed through the brain, and therefore the point for countertrephining.

Fluhrer's aluminum probe consists of an aluminum shaft, 12 inches long, tipped with large conical ends of various sizes. It is so light that when allowed to enter the tract of the ball vertically, it will do so by its own weight and will not make a false passage.

Finally, the value of the Röntgen rays, or X-rays, need hardly be emphasized. A series of skiagraphs may be taken, different portions of the skull being exposed in succession.

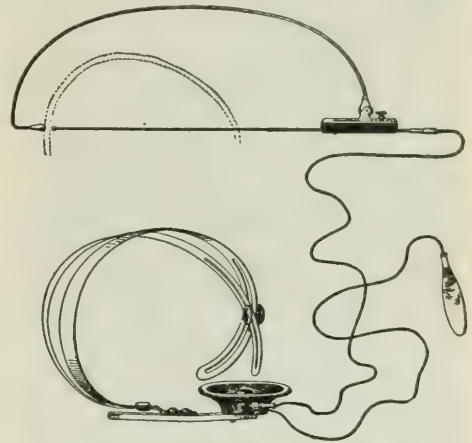
Reid's base line marked by a piece of lead wire will show in the skiagraphs.

F. G. Winter, of Brooklyn, has devised an instrument which combines the principles of Morgan's trajector, Fowler's pressure probe, and Girdner's telephone probe. The trajector consists of a solid bow of aluminum with bulbous tip on the distal end; the proximal pole is hinged to a small steel plate, which is rabbeted to fit a groove on the sliding handle of the pressure-gauge probe. The portion of stem of probe projecting beyond handle is for attachment of the telephonic apparatus. Instead of hand-receiver, a head-receiver may be used, leaving both hands free. (Girdner's telephonic apparatus consists of receiver, conducting wires, bullet probe, and mouthpiece.)

FUNGUS, OR HERNIA, CEREBRI.—When a laceration of the brain and dura mater communicates with a fracture of the skull, it is usually found, especially in children, that a dark-brown or bloody fungus-like mass of cerebral matter protrudes from the wound. This protrusion takes place at any time—a few days to several weeks—after the receipt of the injury. It has been noticed by Guthrie, and confirmed by others, that hernia cerebri is more likely to take place through small than large apertures in the cranial bones. After its appearance the tumor increases quite rapidly to the size of a hen's egg, or even larger, and pulsates synchronously with the brain. In composition and structure it varies. Sometimes it is composed chiefly, if not entirely, of extravasated blood; but the true fungus cerebri consists generally of connective-tissue growth (neuroglia), rarely containing much

true brain substance, but may consist of softened and disintegrated cerebral matter infiltrated with lymph and blood. Under the base of the tumor the softening and red discoloration of the brain extend for some little distance. There may be more or less discharge from the fungus, and escape of cerebrospinal fluid from the interior of the ventricles. It is apt to bleed.

In this affection the mental condition of the patient may not be much



Winter's apparatus for locating bullets.

disturbed at first, although there is generally evidence of cerebral irritation. In many cases stupor speedily comes on, however, and death eventually occurs from encephalitis followed by coma consequent upon the development and increase of intracranial inflammatory effusion. In other cases cicatrization of the surface, with retraction of the tumor, takes place and recovery follows.

As a prophylactic measure the suggestion made by Keen may be carried out: that whenever removal of the dura or brain substance is rendered necessary during the course of operation, a piece of the pericranium

should be entirely detached from the under surface of the scalp flap, turned upside down so that the osteogenetic surface shall be uppermost, and secured to the dura by a few interrupted sutures.

Treatment.—The treatment of this condition is not entirely satisfactory. If the tumor is cut off by the knife or destroyed by the cautery, it generally sprouts out anew, though in rare instances removal has not been followed by reproduction. The best results generally follow the use of **antiseptic dressings** changed once or twice daily, healing taking place by granulation. If it heals slowly, **skin-grafting** may be resorted to. As soon as cicatrization has been completed there is a sudden subsidence, so that, in the place of a bulging mass, there is a marked depression, which is permanent, and may amount to as much as $1\frac{1}{2}$ inches. Pressure by dressings or sponges, though sometimes useful, must be abandoned if followed by symptoms of intracranial pressure or by convulsions.

PNEUMATOCELE.—Pneumatocele, or a tumor filled with air, may result from spontaneous atrophy of the osseous tissues, producing a communication with the mastoid cells. The air then extends underneath the pericranium, forming a painless, smooth, elastic tumor, which is tympanitic to percussion, and which disappears, usually, under pressure. The treatment ordinarily employed is to empty the sac by **pressure** or **aspiration** and then apply a compress and roller bandage.

MICROCEPHALUS.—When a child is born with complete ossification of the skull, even at the fontanelles, or when ossification is com-

pleted soon after birth, microcephalus generally results. To remedy this condition and allow a more rapid expansion and growth of the brain Lannelongue has suggested that a groove, about $\frac{1}{4}$ inch wide, be excised in the skull. This may be made on one side of the sagittal suture or on both sides, and may extend from the front line of the hair on the middle of the forehead well back into the occipital bone, and may have lateral branches. This operation should be done on only one side at a time, and is not devoid of danger, since the general vitality of such children is usually impaired. Keen, of Philadelphia, reduces the time of operation to not more than thirty minutes by using a rongeur forceps which he has devised for the purpose. Stewart, of Philadelphia, denounces this operation as useless.

INFLAMMATION, PERIOSTITIS, OSTEITIS, CARIES, and NECROSIS may occur in the cranial bones. The symptoms are very similar to those produced by the same processes elsewhere. In necrosis of the cranial bones there is always the danger of extension of the inflammation to the membranes of the brain and inflammatory effusion within the skull, producing convulsions, coma, or death. Affection of the petrous portion of the temporal bone gives rise to the greatest danger, on account of the homogeneous structure of the bone and the continuity of the dura mater with the lining of the cavities by which it is perforated. When the frontal bone or the vault is the seat of disease, cerebral complications are less likely to occur.

Symptoms.—When the vault or forehead is affected there is tender-

ness, with some puffiness, and gradual elevation of the scalp into an abscess. If this be opened, the necrosed bone may be seen or felt at the bottom of a sinus or unhealed ulcer. When the petrous portion of the temporal bone is affected, there will be a history of earache, followed by a profuse fetid discharge from the ear, with tympanic perforation, escape of the middle-ear bones, and deafness. When the sphenoid or ethmoid is affected, deep-seated pains in the head, persistent edema of the eyelids, and a fetid discharge from the nose will be present.

Etiology.—These inflammatory disorders of the cranial bones are usually consequent upon injury or constitutional syphilis; more rarely they result from struma (tuberculosis) or follow typhoid fever.

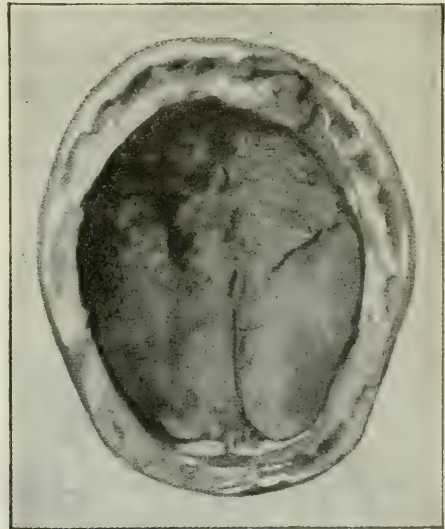
Prognosis.—Necrosis of the petrous portion of the temporal bone is generally incurable, death usually resulting from encephalitis. In necrosis of the sphenoid or ethmoid little can be expected from operative interference, though in the latter case portions of the sequestrum may occasionally be extracted through the nasal cavity.

Treatment.—The treatment of the inflammatory disorders of the bones of the skull follows the general rule of treatment of these disorders. It is, however, especially important that by absolute cleanliness, frequent dressings, and the liberal use of antiseptics the parts be kept, as far as possible, in an aseptic condition. (See also article on BONES, DISEASES OF.)

HYPERTROPHY OF THE BONES OF THE SKULL, with increase of density and obliteration of the diploë, may result from osteitis

deformans or hereditary syphilis. Treatment is seldom required.

[A very interesting specimen of hyperostosis cranii given by Herwirsch to the College of Physicians of Philadelphia was from a woman aged 71, who enjoyed good health up to her 64th year, when rheumatism confined her to bed for one year. During this illness enlargement of head began. She became listless, disinclined to any conversation, and made frequent cries at night. She had insomnia, and near her death she refused food and be-



Hyperostosis of the cranium. (Herwirsch.)

came comatose. Skull at thickest part (right occipital) measured 3.5 cm.; at the frontal, 2 cm., and at the thinnest portion (left temporal), 1.4 cm.; weight of skull-cap 1870 Gm. (4 pounds, 2 ounces).]

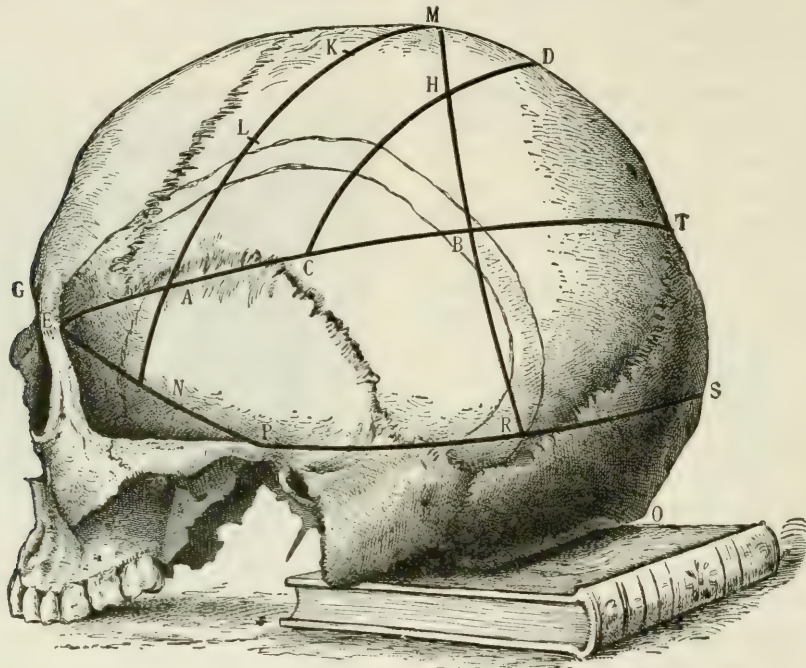
ATROPHY OF THE BONES OF THE SKULL.—This condition is often observed in senile skulls, and appears to be one of the phases of general wasting atrophy incident to senility. When observed in young subjects this condition is generally due to hereditary syphilis. The cranial bones may become so thin that they will crackle on slight pressure. Its favorite location is the

occipital bones; it is often called craniotabes. The **treatment** for these latter cases is that for **hereditary syphilis** combined with **codliver oil** and the **hypophosphites of lime and soda**. All mechanical injuries—blows, falls, etc.—must be averted.

TUMORS OF THE SKULL.—Exostosis, or bony tumor, may occur

side corresponds with a similar growth within the skull.

Round-, spindle-, and giant-celled *sarcoma* may affect the bones of the skull. The tumor may arise in the dura, the diploë, or in the periosteum. As the size of the tumor increases so does the danger and deformity. *Sarcoma* arising from the dura perforates



Cerebral localization. (*Chiene.*)
(*Edinburgh Medical Journal.*)

as a result of injury, but is usually a tertiary syphilitic manifestation, a result of a syphilitic gumma. If the growth is within the skull it is called an enostosis; if external, exostosis.

The general treatment is that for syphilis of the bones. If the tumor is external and gives annoyance, it may be **removed**. If internal, and it can be located by its pressure effects upon the brain, the skull should be **trepined** and the **tumor removed**. Sometimes a growth upon the out-

the cranium and sometimes spreads underneath the scalp, finally breaking through the latter. The opening in the bone, the pulsation of the mass, its partial or complete reducibility, generally accompanied with symptoms of pressure, and the presence of the optic neuritis which often results from it enable one to diagnose this growth.

The growth may be removed, but recurrence always follows. The operation itself involves such danger as

often to be fatal, especially if the superior longitudinal sinus be involved.

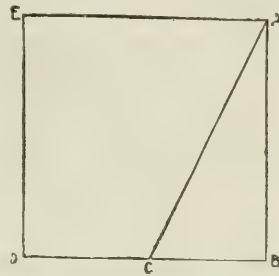
Epithelioma sometimes invades the cranial bones. Like sarcoma, it is a malignant disease, and is treated on the same general principles.

SURGERY OF THE BRAIN.

CEREBRAL LOCALIZATION.—

In addition to the motor areas around the fissure of Rolando, operating surgeons should be familiar with the relations of the temporosphenoidal lobe with ear disease; the supramarginal convolutions in puncture of the lateral ventricles; the angular convolution in word-blindness; the occipital lobe in lesions of sight; in fact, the relations of the whole brain, except the anterior extremities of the parietal lobes. Chiene, of Edinburgh, suggests the following method of cerebral localization: Shave the head and find, in the median line of the skull, between the glabella (*G*) and the external occipital protuberance (*O*), the following points: The midpoint (*M*), the three-fourths point (*T*), and the seven-eighths point (*S*). Find also the external angular process (*E*) and the root of the zygoma (*P*) immediately above and in front of the external auditory meatus. Having found these five points, join *EP*, *PS*, and *ET*. Bisect *EP* and *PS* at *N* and *R*; also bisect *AB* at *C* and draw *CD* parallel to *AM*. The pentagon (*ACBRPN*) corresponds to the temporosphenoidal lobe, with the exception of its apex, which is a little in front of *N*. *MDCA* corresponds to the Rolandic area, containing the fissure of Rolando, and the ascending frontal and the ascending parietal convolutions. *A* is over the anterior branch of the middle meningeal artery and the bifur-

cation of the Sylvian fissure; *AC* follows its horizontal limb. The lateral sinus at its highest point touches the line *PS* at *R*. *MA* corresponds to the precentral sulcus, and, if it be trisected at *K* and *L*, these points will correspond to the origins of the superior and inferior frontal sulci. The supramarginal convolution lies in the triangle *HBC*. The angular gyrus is at *B*. The fissure of Rolando extends from $\frac{1}{2}$ inch behind the midpoint between the glabella and the inion, downward and forward, for $3\frac{3}{8}$ inches at an angle of $67\frac{1}{2}$ degrees. This angle may be



Method of finding the fissure of Rolando.
(Stewart.)

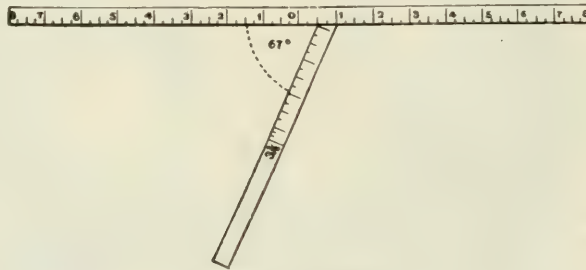
found by taking a square piece of paper and folding one corner back on the line *AC*, i.e., from the middle of the line *DB* to the corner *A*. The side *EA* is then placed on the middle line of the head, and the line *AC* corresponds to the fissure of Rolando, the angle *EAC* being $67\frac{1}{2}$ degrees. Horsley's cyrtometer is an instrument for marking out the fissure of Rolando. (For motor, speech, and special sensory areas, etc., see illustrations in TUMORS OF THE BRAIN.)

TECHNIQUE OF INTRACRANIAL SURGERY.—It is important to notice that these operations may be rendered necessary by traumatic or pathological lesions. The two

should be considered quite separately, since comparison between them is almost impossible. In traumatic cases operation is undertaken, as a matter of necessity, suddenly, perhaps with instruments not entirely suitable, but certainly without delay, the condition of the patient not permitting it. No previous preparation of the patient or preparatory treatment has been possible. His general condition is unknown. Septic elements are often—indeed, generally—present, not only upon the surfaces, but have, perhaps, been introduced deeply into the tissues by the trau-

matic cases, as circumstances permit or seem to indicate. The head may have already been opened before the case is seen by the surgeon, who is forced to do patchwork.

In operations for pathological conditions the reverse of what has been said exists. The proper time is chosen; all things are prepared beforehand; the proper light is provided; asepsis is secured; there is a due regard for both local and general cleanliness; the condition of the internal organs has been learned, and they have been made to functionate properly; a well and carefully con-



Horsley's cyrtometer.

matism for which the operation is undertaken, and infection may have already occurred within the head. The condition of the kidneys may be unknown to the surgeon; for, even though the urine be examined immediately after the injury and before the operation is undertaken,—and this should always be done,—yet, if the patient has been transported a certain distance in cold weather, or the surface of the body has been largely uncovered, as is not unusual after an injury, albumin may generally be found, and possibly also casts. The details in operative work, also, are often obscure, and landmarks obliterated, both within and without the skull. The head is opened, in trau-

sidered operative procedure is carried through after due study and consideration, and all necessary things are at hand. The operation then is undertaken in the best way for the patient's welfare.

An aseptic field of operation is pre-eminently essential to success. In cerebral surgery it is best that the whole head should be prepared and cleaned in all cases, unless of a very minor character.

In traumatic cases the head is to be shaved and the skin cleaned with green soap, hot water, nail brush, and carefully scrubbed. The ears should be cleaned out and filled with sterile cotton. The eyes should be closed with pads of sterile cotton. The

scrubbing should be done, not only upon the surface, but, if a wound exists, it should be scrubbed likewise, and an effort made to get out any dirt which has been forced beneath the skin; punctured wounds should be laid open; tracts beneath the skin should be opened and scrubbed; the edges of irregularly bruised tissue may be trimmed away and a clean surface obtained. When coal dust or grease has been forced beneath the surface, scrubbing with a nail brush and soap and washing with ether and alcohol will often be sufficient to obtain a clean surface. Dirt ground into the surface or edges of broken bone can be scraped away, or nibbled away with forceps, so as to be gotten rid of. After cleansing the head for traumatic operations a towel wrung out in **corrosive sublimate** solution (1:2000), or sterile water, perhaps, can be used as a cover for the prepared region until the instruments and other things are ready.

In preparing a patient for an operation undertaken for some pathological condition (not traumatic, of course) the patient is prepared a day before the operation, and then again just prior to the operation. As a prophylactic measure against meningitis Crowe suggests the use of hexamethylenamine, which passes rapidly into the cerebrospinal fluid, imparting to it antiseptic properties; it is given in 5-grain doses three times daily, before and after the operation. Blood-pressure readings should be taken, at frequent intervals, by a special assistant; a fall in the blood-pressure below 100 mm. should cause the operation to be interrupted temporarily, to be completed at another sitting. The head after being

shaved is carefully examined for scars, etc. It is disinfected with **soap and water, alcohol, and sublimate solution** (1:4000) the day before operation, and again at the time of operation. An **alkaline (sodium bicarbonate) solution** may be found useful to remove dandruff from the scalp, but Tiffany advises the use of **green soap**. Shaving and scrubbing with green soap, or a poultice of green soap applied over the surface after shaving and left on for a couple of hours and then scrubbing afterward, is efficacious. The green soap should be removed with alcohol, then ether, and the clean scalp tied up in a moist **corrosive sublimate dressing** until the following day; a repetition of the cleansing as already described gives a clean surface upon which to operate.

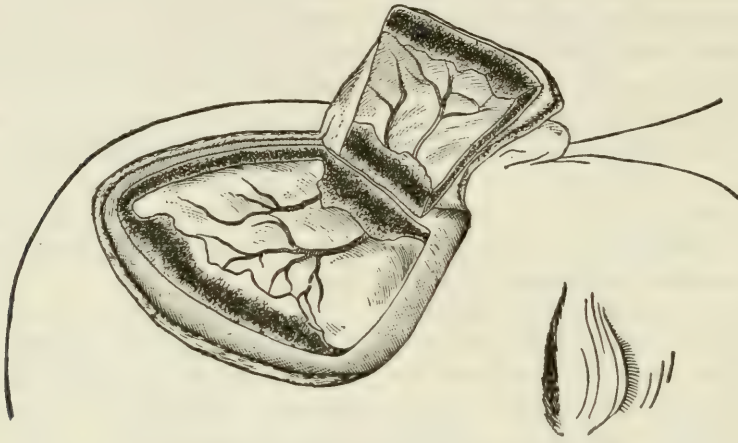
The dry scalp may be painted with a 5 per cent. tincture of iodine, which has become of late the most popular antiseptic measure in preparing the scalp for operation.

As the brain is to be covered in after the operation, a large horseshoe-shaped osteocutaneous flap with a diameter of about 3 inches, the base turned toward the source of the blood supply, is probably the most effective manner of uncovering the brain. It should be cut in one piece so as to permit of being turned down. This breaking down at the base is facilitated by cutting across the bone with sharp forceps, or otherwise, and it should be so cared for during operation that the skin and bone are not torn asunder; it may be necessary to envelop it in a cloth wrung out in hot, sterile, **salt solution**.

The patient being in the semirecumbent position, in order to dimin-

ish the amount of hemorrhage, the fissures—so far as desired—may be marked on the scalp with an aniline pencil; and also three points on the bone beneath—the point at which the center-pin of the trephine is to be applied, and the upper and lower ends of the fissure of Rolando at points just outside the flap; the center-pin of another trephine may be used for this purpose. The cutting of the bone is to be done by the instrument

As soon as the holes have been drilled a director with a beak turning off almost at a right angle, and grooved so as to properly direct a thin piece of whalebone between the dura and bone, is inserted with the beak placed between the dura and skull. The whalebone, threaded on the end with a long piece of strong and thin silk, is then pushed gently on in the direction of the other trephine opening until it comes into view, when the



Temporary resection of the skull. (*Chipault.*)
(*Gazette des hôpitaux.*)

with which the surgeon is most familiar; the trephine, the rapidly revolving saw, chisel and mallet, the Gigli wire saw, all have their advocates. Should the opening not be large enough in the skull, there should be no hesitation to cut away the borders of the opening with rongeur forceps until sufficiently large.

The Gigli wire saw in resecting a portion of the cranium is used as follows: Having decided upon the outline of the three-sided flap which is to be turned down, two small incisions are made at the upper corners just sufficiently large to allow the application of a small trephine.

thread is partially drawn out. Each of the remaining sides of the flap is treated in a like manner. One end of the thread is attached to a wire screw, and the saw drawn through between the skull and the whalebone. The skin incisions are now completed and the bone sawed through.

There is a difference between the sides of the skull and the top; bone need not be put back into the temporal fossa, for, by reason of the presence of the dense temporal fascia, there is not much sinking in; it is otherwise at the top and front of the skull, as an absence of bone results in a deep depression. The time consumed in

exposing the brain is largely the result of the bone cutting. It is therefore a matter worthy of thought and careful consideration whether, when it becomes necessary to operate within the head, it may not be expedient to raise a large flap, remove the necessary bone, replace the flap, and allow it to heal. A month or two afterward the surgeon can operate to remove the pathological condition more rapidly, bone not obstructing. All operations on the brain should be done in two, or even more, stages, with a few days' interval between.

Trephining *per se* is practically without risk, but the later development of paralysis, spurious meningocele, epilepsy, and abscess is always to be considered. To the general surgeon, fractures with their concomitant brain injuries will always constitute the majority of cases in which operation is indicated. Here X-ray gives an assured estimate as to the damage to the skull, while a lumbar puncture will give an idea of the damage to the brain. Many basal skull fractures are doomed from the moment of the accident. In about 200 cases seen in the Cincinnati General Hospital, 37 per cent. of the deaths occurred in less than 6 hours, and 56 per cent. in the first 12 hours. The author can recall but 2 cases in which he believes that an operation foiled death in cases which appeared hopeless. In cases living longer, a **spinal puncture** will often accomplish all that a decompression will, and is destined to take its place in many instances, as it relieves the edema when the bleeding has stopped. **Decompression** is indicated in all cases in which the patients become progressively or suddenly worse, showing signs of increased intracranial pressure. The rule that localizable brain injuries with fracture should be operated upon stands.

From experience along the western front in the present European War, it appears that the brain substance is not easily or rapidly infected. The consensus of opinion of the war surgeons is that none but the simplest operations should be done except at a base hospital. If a trephining is to be done, it should be some distance from the injury, and the latter, if not too large, excised. Gauze drainage is to be entirely avoided, and where drainage is absolutely necessary, it should be done with gutta-percha or strands of silkworm. Primary union is to be sought for here as elsewhere.

A great many brain abscesses are best treated by the otologist. There are a number of cases of this type, however, coming to the general surgeon. While the results are more favorable than formerly, they are still anything but encouraging, and the patient is often left with hemiplegia, the subject of convulsions or of mental defects.

Brain tumors as nothing else tax the diagnostic acumen of the surgeon. In only 40 per cent. of the cases is the tumor found at operation. This is due to the silent process in some instances, and the localizing symptoms, if present, are slight and difficult of clear interpretation. Gliomata often so resemble the normal brain substance that although perfectly exposed they may not be recognized. Of the 3 subcortical tumors that the author has been able to remove, 2 died of a recurrence within a year. The mortality from operation is high, although Cushing reports 136 operations with only 4 deaths. Operations upon the cerebellum which were considered unjustifiable a little over a decade ago have been made quite as safe as pre-tentorial tumor operations, due partly to the fact that a large proportion of these tumors have turned out to be cysts requiring only drainage, and partly because decompression promptly relieves the most distressing symptoms. Deaths due to respiratory failure must not be forgotten in this type of

cases. J. Ransohoff (Interst. Med. Jour., April, 1917).

It has been observed that opening the skull, even in incurable cases, may diminish pain and optic neuritis. The dura is to be divided and turned aside as a flap, the line of division being about one-third of an inch internal to the bone section, so as to allow of suturing and replacement. In general, the dura is to be respected and treated like other serous membrane, and with no more consideration. No antiseptic should be used after the dura is opened.

Hemorrhage from the skin may be arrested with **hemostatic forceps**. **Encircling the cranium with a rubber band** has yielded satisfactory results, especially by the Laplace tourniquet. A bandage is placed on the patient's head anteroposteriorly and laterally from ear to ear. An ordinary piece of rubber tubing is wound snugly four times around the patient's head. The bandage is then cut at the vertex, and the four strips which result serve to bind together the turns of rubber tubing at the forehead, occiput, and both temporal regions. In this way the tourniquet cannot slip, and the strips of bandage enable the operator to have perfect control of the tourniquet and perfect hemostasis results.

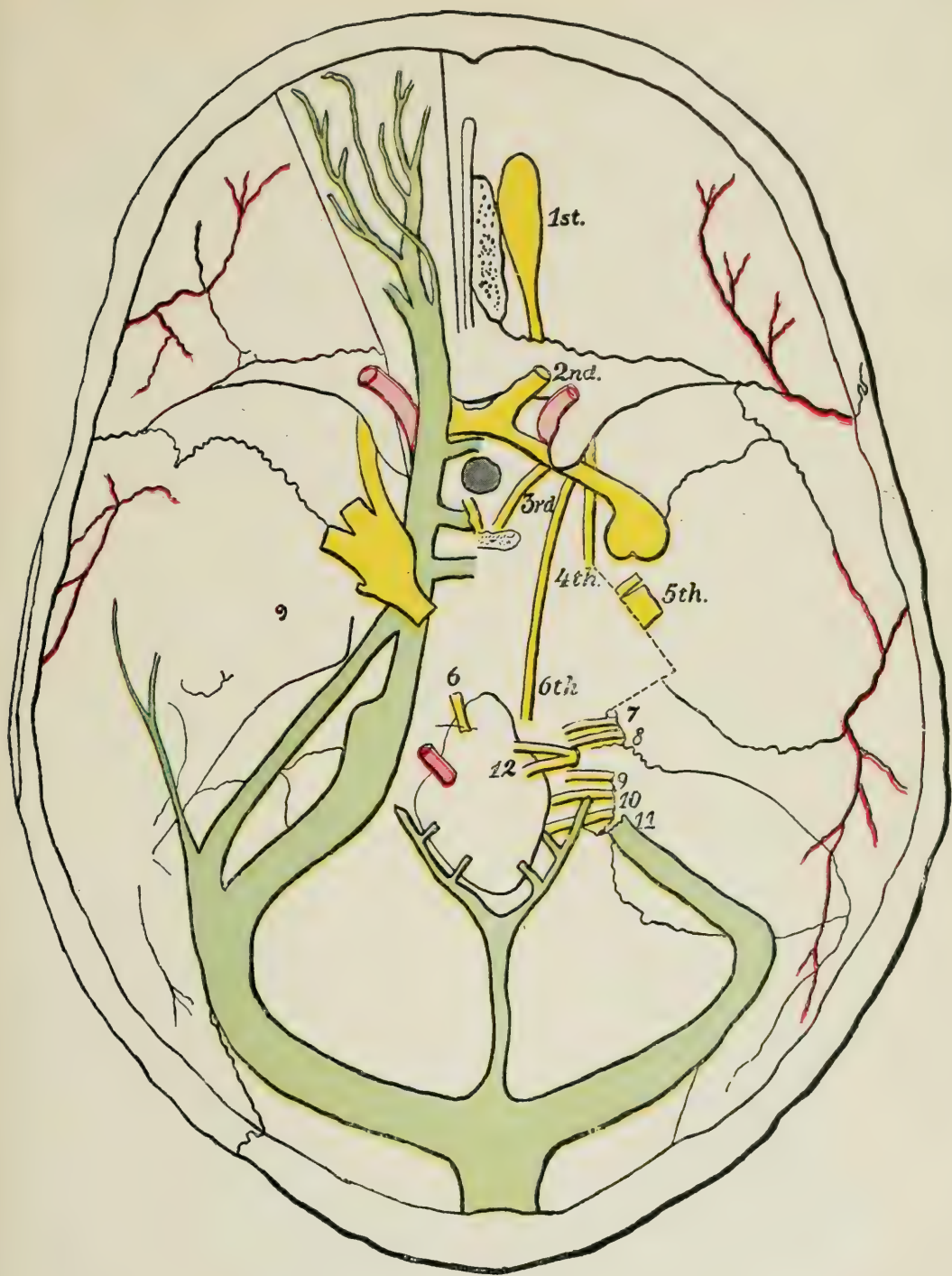
Hemorrhage from the bone during the cutting may be arrested by **Horsley's aseptic wax** or **pressure with dry gauze**. By crushing in the edges of the bone with heavy forceps, by gauze pressure, or best by Horsley's wax (beeswax, 7; almond oil, 1; salicylic acid, 1), bleeding from the diploë may usually be arrested. In hemorrhage from the dura a fine **ligature** passed around the artery and tied suffices to stop bleeding. Ve-

nous hemorrhage may be arrested in the same manner. Hemorrhage from a sinus may be arrested in several ways: by **suturing** the wound in the vessels with a curved needle, passing the thread around it and tying it, and by **gauze pressure**. After turning the dura back and exposing the surface of the brain, bleeding vessels are to be looked for and tied carefully, without dragging, by two **ligatures**, and divided between. Forceps will generally tear off, and should not be employed, save very temporarily. Serrefines may be of use.

For cranial hemostasis, in addition to the tourniquet for the scalp, and wax for diploetic and emissary bleeding, the author uses gauze pledgets, dry sterile cotton, fragments of raw muscles and other tissues, as well as sections of organizing blood-clots for superficial meningeal bleeding, and silver "clips" for inaccessible individual points either in the dura or brain. H. Cushing (Annals of Surg., July, 1911).

In all operations upon the head, hemorrhage can be decreased notably by maintaining the head so elevated that the field of operation is higher than the patient's trunk. Many operators place an elastic band tightly about the skull, approximately along Reid's base line, before craniotomy, but not infrequently the resulting increase of venous hemorrhage is greater than the decrease of arterial hemorrhage. In such a case removal of the constricting circlet promptly reduces the bleeding. Bleeding from a scalp flap with base not excessively broad may be controlled readily by catching the base of the flap in rubber-covered forceps. This removes the need of biting and bruising the margin of the flap with toothed hemostatic forceps.

Hemorrhage from the diploe may be very annoying. Pressing Horsley's wax into the openings may suffice, or warm, soft, sterile gum



Base of skull, showing the different fossæ, with nerves and sinuses, which may be compressed by tumors.

chicle may be pressed in. Chicle is more tenacious than the wax, but it is not absorbable and must be removed before the closing of the wound. Threatening hemorrhage from a large canal of the diploe may be controlled by inserting the pointed or conical end of a previously boiled soft pine stick. Such pegs are also useful in closing foramina communicating with intracranial sinuses. Crushing of the exposed ring of diploe by light blows with a metallic punch is often of service in hemorrhage from the spongy layer of the cranial bones. J. R. Eastman (*Amer. Jour. of Surg.*, Jan., 1912).

Civil life traumas of the brain are: (a) brain traumas without visible wound; (b) scalp wounds with no apparent fracture; (c) Gutter fractures of the skull; (d) depressed fractures; (e) penetrating wounds of the brain, such as punctured wounds (as from a bayonet); (f) wounds with a missile remaining in the brain, (g) and through and through wounds. Gutter fractures always have associated with them fractures of the inner table. Penetrating wounds are supremely destructive of the brain tissue. The chief complication is infection. Cerebral herniæ also become infected.

The line of treatment includes (a) primary cleansing of the wound; (b) removal to hospital for operation; (c) X-ray studies; (d) excision of scalp and bone wounds; (e) discriminating removal of foreign bodies; (f) covering of the exposed brain; (g) complete or partial closing of the wound; (h) only superficial drainage except with abscess; (i) lumbar puncture; (j) prolonged rest in bed. J. W. Long (*So. Med. Jour.*, Jan., 1918).

The method inaugurated by British surgeons especially, such as Horsley, Sargent and Holmes, by the application of **muscle strips** to obtain hemostasis of the bone and venous sinuses, the writer considers most effective and satisfactory. The technique is simple. A piece of any muscle sufficient for the purpose is cut. After rapid removal of clots with a tampon,

the piece of muscle is placed on the bleeding point and pressed down firmly with the finger or any soft instrument. It adheres in a minute or so and stops the hemorrhage completely. It is applicable only to hemorrhages from the bone or from the venous sinuses. E. Velter (*Presse méd.*, p. 31, 1918).

Tumors within the brain will push up sulci from below, so that vessels can be tied more easily than in the normal brain. A growth should be encircled by ligatures under these circumstances. The material used in ligating varies. Tiffany used very fine sterile silk. Finally, there is that form of hemorrhage which may come from the exposed surface of a growth, and is usually denominated parenchymatous. Pressure with gauze will effectually arrest this. It may be that the gauze can be taken away at the end of the operation; usually it is to be left protruding and removed in two or three days.

In regard to the anesthetic: Special indications for one or the other anesthetic lacking, **chloroform** may be employed, as intracranial congestion is probably lessened thereby. Under ether the face becomes congested; a similar condition may obtain within the skull.

Tiffany has a cast of the brain at hand to refer to, while operating, for comparison with the exposed area. **Electrical stimulation** of the exposed area, by methods now well known, aid the operator.

When operating for a tumor of the brain which is covered by the cortex, the color and consistency of the exposed area may give information, but an incision will probably be of advantage. Certain growths have the same consistency as the brain, and

have been traversed by needles without recognition; hence color and consistency failing to be recognized, probably an incision into the brain is best; touch followed by incision, if the tumor does not present, is far better than touch followed by puncture, unless a cyst is discovered.

To expose the occipital region of the brain the writer advises the making of a flap of bone and scalp, with the base down. The bone flap approaches the middle line as far as is possible without danger to the longitudinal sinus. Upward it extends beyond the transverse sinus and laterally it exposes the sigmoid sinus. The flap having been turned down, the dura is cut just inside these vessels and also turned down. This exposes the cerebellum. Upon inclining the head to one side or the other the posterior surface of the petrous portion of the temporal bone is laid bare, and a small vein passing from the petrous sinus to the cerebellum should be ligated and severed. The lobe can then be carefully displaced with the brain spatula, and the facial and auditory nerve roots exposed. If, instead of pushing the hemisphere inward, one displaces it more upward, the roots of the tenth, eleventh, and twelfth nerves are exposed. Great care must be taken not to tear the pia or the ventral layer of the arachnoid. With care the entire posterior fossa can be explored and any extracerebellar tumors removed. If no lesion is detected by sight or touch, the cerebellum may be incised to a depth of an inch without danger. If, in spite of pressure symptoms, nothing is found, the fourth ventricle may be tapped to determine the existence of internal hydrocephalus. Krause (*Archiv f. klin. Chir.*, Bd. lxxxi, Nu. 1, 1907).

To gain access to the optic chiasm, hypophysis, and anterior pons region, the author opens up the sphenoidal sinus. This is easily done through the roof of the nasopharynx, pushing

the mucosa and periosteum apart, with the incision in the median line, and opening a passage through the body of the sphenoid. Before the operation a strip of cambric is passed through each nostril and out through the mouth and tied around the ears, thus holding the soft palate out of the way. The tongue is held down by a strip passed in through the pharyngotomy incision and out through the mouth, the ends being tied tight together over the chin. The instruments must have longer handles than usual and be a little stronger to work at the depth required. Löwe (*Zentralbl. f. Chir.*, April 10, 1909).

In many cases of tumor, the cortex is greatly displaced, but it is also probable that where the cortex is removed restoration of function, to a certain extent at all events, will follow. Circumscribed growths may be taken away by spoon, finger, knife, etc., but infiltrated growths, while they may be taken away, so far as can be recognized by the operator, give most unsatisfactory ultimate results, recurrence being the rule. The dura, being removed, should be replaced by gold foil, as advised by Beech, of Boston; or by rubber tissue, as practised by Abbe; or by a thin sheet of celluloid, as employed by McCoch; or egg-membrane (Freeman) to prevent adhesions between the brain and scalp, the advantages of which are that it is inexpensive and can be easily obtained, that it is not in the full sense of the term a "foreign body," and, though it ultimately becomes absorbed, it remains intact sufficiently long to accomplish the purpose for which it was inserted. There is, moreover, no danger of subsequent infection requiring a second operation and leading to extensive formation of connective tissue.

Experiments on dogs which showed that a piece of **fish bladder** heals into place when introduced to fill a gap in the dura. It becomes gradually absorbed, but a kind of membrane forms in its place. A month or two after its implantation this membrane fills up the gap in the dura, its thickness and texture being strikingly like that of the normal dura, while there is no adhesion to the brain below. Hanel (*Archiv f. klin. Med.*, Bd. xc, Nu. 3, 1909).

One of the practical results of the newer work on organ and tissue transplantation has been the free **transplantation** of fascia for dural defects. Kirschner was the first who experimentally demonstrated that fascia could be successfully transplanted into dural defects. His histological examinations showed that the transplants remained alive and did not become adherent to the dura. The technique of the operation is very simple. The fascia lata is exposed and the fat carefully removed from its surface. A suitable piece of it is excised and is sutured to the edge of the dural defect with its muscle surface toward the brain. - Although other methods of closing dural defects have been devised, this is by all means the method of choice. As large a portion as practically necessary is always obtainable; it is always aseptic; no preliminary treatment of the tissue is necessary, and the material (being autoplasmic) offers the best chances for healing in place. W. Denk (*Archiv f. klin. Chir.*, Bd. 97, Nu. 2, 1912).

Intracranial sutures may be of silk or fine catgut. To obtain a bone flap where it is thought necessary, when the natural bone is lacking, different expedients have been made use of: the periosteum from the tibia has been transferred to the head; the outer table of skull, while connected with the skin, has been fashioned as a flap to turn over and cover the defect; the removed bone, perforated

with holes so as to permit of drainage, has been used; bone chips obtained by the use of the chisel or gouge on the adjacent sound bone have been placed on the dura, as a mosaic with the outer side downward. These are known as **autoplasty**. When a piece of foreign material, as silver, celluloid, decalcified ox bone, calcined ox bone, or aluminum, is used, it is called **heteroplasty**.

The writer found that **cartilaginous transplants** could be used in reparative surgery and that loss of substance in the skull could be repaired by grafts of cartilaginous substance. Cranial deformities resulting from the destruction of frontal parts and especially the orbital arcade are easily corrected by cartilaginous grafts; the results are very satisfactory and seem perfectly stable. The pieces of cartilage used by the writer were obtained from subjects other than the one operated on. H. Morestin (*Bull. et mém. Soc. de chir. de Paris*, xlii, 333, 1916).

For the skin, sutures of silkworm gut are desirable. When the head has been opened for extensive operation, drainage is important. A piece of silver wire hooked in the lower angle of the wound, or a small drainage-tube will answer; if the latter, it should be removed after twenty-four or forty-eight hours, unless abscess develops, when it should remain several days. A voluminous dressing of sterile absorbent gauze secured by roller bandage or night cap will afford protection and support. The time when dressings are to be changed will vary with the conditions present. As a rule, half the stitches may be removed on the fifth or sixth day; the remainder by the seventh or eighth day. Absolute quiet of mind and body should be

observed for the first week, and there should be no visitors, letters, or other disturbance for two weeks at least.

Following technical points in cerebral surgery emphasized: (1) Continuous auscultation of the heart beat and respiration during anesthesia; (2) subtemporal decompressive operation as an early measure and preliminary step to a possible tumor extirpation; (3) dangers of lumbar puncture in the presence of a degree of subtentorial pressure sufficient to produce a cerebellomedullary foraminal hernia; (4) value of a continuous lumbar drain during the course of explorations for lesions of the hemispheres; (5) principle of outward dislocation of normal tissues to avoid the risks of compression or mutilation during deep explorations. Cushing (Jour. Amer. Med. Assoc., Jan. 16, 1909).

Report on 150 cases of head injuries operated in a casualty clearing station in the absence of X-ray aid. The writer upholds early operation in all head cases to prevent sepsis. Men with head wounds do not, as a rule, return to the colors. Lodged bullets should be removed at home hospitals. As shell fragments are much more apt to induce sepsis, their removal when possible, even at a clearing station, is indicated. Comparing the large cranial openings of English surgeons and the linear or angle incision and small trephine openings of the French, the writer favors the latter as more appropriate in casualty clearing stations where lack of equipment obtains. The average operator can always remove dirt from the wound by incision. Don (Lancet, May 20, 1916).

Precautions in Cerebral Surgery.—

It was the failure to appreciate the importance of early wound excision, the evil effects of drainage and the possibility of primary suture after excision that for so long kept the operative mortality in brain injuries above 50 per cent. during the war. Subsequent practice was as follows:

In scalp wounds the external table occasionally showed no evidence of trauma, and in such cases the scalp was sutured without further interference. When preliminary neurological examination gave evidence of intracranial involvement, the skull was opened at the point of injury and usually a non-pulsating, discolored dura was disclosed. In such cases dural incision was practised, providing infection had not become established. A quantity of disorganized brain substance and blood clots was extruded, after which the normal pulsations would reappear and the relief of tension permit immediate closure of the dura by suture—a procedure possible because of the early excision of the traumatized area before infection had become established.

The operative technique at the front was complete **excision** of the scalp **wound**, avoiding contact with the lacerated edges, removal of the area of bone injury *en bloc* by cutting around it with a DeVilbiss rongeur, and not allowing the instruments to come in contact with the infected tissues in the center of the piece removed. Evacuation of disorganized brain substance was rapidly effected by having the patient cough or blow, after which a soft rubber catheter was inserted to palpate any retained foreign bodies or bone fragments already expressed.

In ventricular penetrations it was found possible to insert long, narrow retractors and **remove foreign bodies** under direct inspection. When the ventricle was not involved and the toilet of the brain tract was completed, a 2 per cent. solution of **dichloramine-T** was usually introduced and allowed to run out during the completion of the operation. Large dural defects were covered with pericranium. The scalp was always closed by **primary suture**. The only **drainage** ever used was a small piece of rubber glove placed in one angle of incision and removed next day at first dressing. K. W. Ney. (N. Y. Med. Jour., cx, 229, 1919).

SURGERY OF THE LATERAL VENTRICLES.—A number of cases have been reported in which the lateral ventricles have been opened by injury, 5 cases from simple cranial fracture occurring in children, of whom 3 recovered. There are also recorded 7 cases of compound fracture with injury of the ventricles, in which 4 of the patients recovered, and 2 cases of primary rupture of the ventricles by compound fracture, in which both patients recovered. In fungus cerebri a communication with the lateral ventricles is sometimes established, manifested by a continuous flow of cerebrospinal fluid therefrom, in which recovery has followed. Keen has shown, moreover, that puncture of the lateral ventricles through the brain substance can be done accurately, and that a drainage-tube may be introduced into the ventricles and remain several weeks without inducing encephalitis or meningitis, and that even irrigation of the ventricles from side to side after bilateral trephining can be done without discomfort to the patient. From these facts it follows that in cranial fractures involving the ventricles we should not consider the accident as necessarily fatal, but should employ the same antiseptic precaution, methods, and treatment as though the ventricles had not been involved, and with a reasonable hope of recovery.

If the ventricles are to be tapped, Keen advises the lateral route. A $\frac{1}{2}$ -inch trephine opening should be made $1\frac{1}{4}$ inches behind the external auditory meatus and the same distance above Reid's base line (an imaginary straight line drawn through the lower edge of the orbit and the

meatus auditorius externus). Then the grooved director or a small tube (caliber No. 5 of French catheter scale, or a little larger) should be thrust carefully and steadily into the brain in the direction of a point $2\frac{1}{2}$ to 3 inches above the opposite meatus. If the lateral ventricle is of normal dimensions, says Keen, it will be reached at a depth of 2 to $2\frac{1}{4}$ inches, but if distended it will be reached at a less depth. The entry into the ventricle will be recognized by the instantly diminished resistance and also by the escape of cerebrospinal fluid. Drainage, either by inserting a small bundle of horsehair doubled like a hairpin, with the rounded ends inserted first, and passed through the tube, or by carrying a rubber drainage-tube of the same size into the ventricles. Asepsis must be absolute, or the result will be necessarily fatal.

This operation has been done for the relief of acute hydrocephalus with promising results (Mayo Robson reports a cure); in chronic hydrocephalus several operations have been made, but without success.

Value of simple **exploratory puncture** of the brain through the intact skull emphasized. Illustrative instances of extradural hematoma related. In case of negative findings the author punctures at several points, and aspirates until something comes. In the case of a young woman presenting symptoms of tumor in the frontal lobe puncture revealed normal conditions at this point except for an unusual amount of cerebrospinal fluid. Puncture of the fourth ventricle revealed primary acquired hydrocephalus, about 60 Gm. of cerebrospinal fluid gushing out, after which the symptoms subsided to complete recovery. Lumbar puncture gave no hint of the conditions in the brain in this case. K. Pollack (Mit-

teil. a. d. Grenz. d. Med. u. Chir., Bd. xviii, Nu. 1, 1907).

Technique of aseptic **puncture** of the **brain** described. The author recommends: puncture from above, through the frontal bone, about 2 cm. from the central line and 3 cm. from the precentral fissure. The needle must be pushed downward and backward, striking the ventricle at a depth of 5 to 6 cm. A ring or shield fitted to the drainage-tube will avoid its going deep enough to injure the opposite wall. Subcutaneous drainage is most advantageous. Tillmanns (*Lancet*, Oct. 24, 1908).

Technique of puncture of corpus callosum described. A small trephine opening is made behind the coronal suture and a cannula introduced down to the falx cerebri and along this to the corpus callosum, through which the tip of the cannula is pushed. This opens a passage for the cerebrospinal fluid from the ventricle into the subdural space and thus reduces the intracranial fluid pressure in the ventricle. Von Bramann and Anton (*Med. Klinik*, Nov. 28, 1909).

CEREBRAL CONCUSSION.—It is very difficult to establish clinically a distinction between concussion and contusion of the brain. However, concussion conveys the idea of the brain, as a whole, having been violently shaken under the effect of a traumatism, resulting in a disturbance of function, without any appreciable lesion of the brain substance. The boundary between the two conditions must, therefore, be more imaginary than real.

In the mildest grade of concussion there is a brief diminution of the blood-pressure in the part; its tension is temporarily lowered. If the violence is somewhat greater, then there is superadded to the former condition a disturbance of the cellular constituents composing the surface of

the brain. A disturbance or disarrangement of the molecular elements of these cells, even though it be microscopically minute, must suffice to induce functional derangement. As the violence is increased the effects are correspondingly greater, and may even reach that point where the functions of life cease immediately and permanently. In the severe form there are lacerations of the brain tissue and blood-vessels. These lacerations may give rise to hemorrhage in such amount as to exert pressure on the brain and produce symptoms of compression.

SYMPTOMS.—These vary from temporary giddiness to collapse and death. In a typical case there is unconsciousness, but the patient may be partially aroused by shouting, or pricking the soles of the feet with a needle. Relaxed muscles, cold and pale skin, subnormal temperature, slow and shallow respirations, weak and rapid pulse, dilated pupils equal in size and reacting to light, sluggish or absent reflexes; relaxed sphincters, causing involuntary bowel movements, but retention of urine from relaxed bladder muscle, mark the typical case. Transient paralyses if present mark the stage of collapse, which may last from a few minutes to hours, and end either in death or in reaction, which may be preceded by a convulsion or more commonly by slight movements of the extremities and vomiting. The symptoms in the latter case gradually disappear, the temperature rises, perhaps to 100° F. or slightly higher, and headache, drowsiness, or irritability appears and may persist for several days.

Miles has found from experiments that there is a temporary anemia of

the brain in concussion. This is the reflex result of the stimulation of the restiform bodies, and perhaps other important centers in the region of the bulb. These parts are stimulated by the cerebrospinal fluid, which rushes through the aqueduct of Sylvius, the foramen of Magendie, and the subarachnoid space when a severe blow is dealt over the head. Therefore, this cerebrospinal fluid will disturb the equilibrium of the ultimate nerve cells throughout the nervous system.

PROGNOSIS.—This should be guarded, although complete and permanent recovery usually follows. The early dangers are compression from hemorrhages, and inflammation of the brain or meninges. The possible sequelæ are cerebral irritability, inveterate headache, vertigo, loss of memory, change in character, insanity, epilepsy, diabetes, neurasthenia, and more rarely tumor or abscess. The patient's memory is frequently defective for the events immediately preceding the accident.

Trench warfare has developed a serious and almost unvarying concussional syndrome. In 168 cases the writer established 6 different groups: 12 cases of mutism with or without deafness and with or without true auditory lesions. Most of the cases of uncomplicated mutism recovered spontaneously or under re-education and reassuring words; 21 of painful concussion with frontal headache persisting for months, mental depression preventing sustained work, slight dizziness, unsteadiness in the standing position, and unilateral deafness, slowly recovered from; 17 cases of labyrinth concussion of all grades, from a simple dazed condition to marked ataxia and astasia abasia; 54 cases of the typical concussion syndrome, characterized by mydriasis

persisting from 2 weeks to several months. H. Aimé (*Presse méd.*, Feb. 22, 1917).

TREATMENT.—During the stage of collapse apply **external heat** and give **stimulants**, alcohol being, however, interdicted because of its exciting effect on the brain. Overstimulation should be avoided. When reaction begins, the patient should be kept in bed, **absolute quiet** maintained, an **ice-bag** placed **on the head**, the **bowels purged**, and the **catheter** used if there is retention of urine. **Sedatives** may be prescribed if necessary. A **liquid diet** is best in these cases.

A very important factor in the after-treatment of cerebral concussion is to order the patient absolute and prolonged **rest**, whether the concussion has been severe or only slight. He should abstain from all business or worries of any kind. The best plan is for him to go down to a little country place, and avoid all excitement. Health resorts are not calculated to afford the mental rest which is so needful. See also **CEREBRAL ABSCESS**, **NERVOUS SYSTEM: ENCEPHALITIS**, and **FRACTURES**.

CEREBRAL CONTUSION AND LACERATION.

A contusion of the brain always accompanies any serious injury to the cranium. Such contusion can exist without necessarily having a fracture of the skull; but on the other hand, a fracture of the skull is always accompanied by cerebral contusion.

SYMPTOMS.—The symptoms of contusion of the brain, referring to loss of function, are characterized by their diffuse or generalized condition. Hence, they differ materially from those of compression, which refer

absolutely to distinctly localized lesions. Vomiting often occurs after the injury. Respiration is superficial, but may be deep and stertorous. Fever has been observed in contusion of the brain, especially in case of injury or irritation of the median portion of the corpus striatum, and the mesencephalon, such as the posterior corpora quadrigemina and the sensory nucleus of the fifth nerve (Kocher).

It has long been a mooted question whether contusion could always be differentiated from concussion of the brain by any special symptom. Clinically this does not exist. In a general way the symptoms of concussion, resulting from a lighter form of traumatism, produce less material disturbance and are therefore more transitory, whereas in severe contusion the symptoms persist and are sometimes aggravated, because of the possibility of an encephalomeningitis complicating the case. Loss of consciousness, partial or complete. Paralysis more or less complete of different portions of the body. A cold, clammy condition of the skin. A feeble, fluttering heart. After a few days these symptoms disappear gradually, depending upon the absorption of the extravasated blood. After recovery the patient may suffer for a time from vertigo, headaches, and loss of memory, in addition to a general debility and malaise.

While a vigorous brain may undergo a severe traumatism without injury, a less resistant brain may easily react with serious consequences to a slight traumatism. Weyert (*Münch. med. Woch.*, March 30, 1909).

PATHOLOGY.—Contusion does not necessarily bear a direct relation

to the seat of injury. Bergmann maintains that when the traumatism has been applied over a large area, and violent enough to depress the skull, not only is there severe contusion, or laceration of the subjacent brain structure, but the corresponding portion of the brain on the opposite side has likewise undergone considerable contusion, by the force being transmitted through the brain, against the skull, opposite the seat of injury.

The superficial layers of the brain are most likely to be affected, especially since the gray cortical substance is the most plentifully supplied with blood-vessels. In fractures at the base of the skull contusion of the brain exists mostly at the temporo-sphenoidal lobes. The occipital lobes are not so readily affected, on account of the protection offered them by the cerebellum. The following distinction exists between a spontaneous cerebral capillary hemorrhage and that resulting from a contusion, viz.: In contusion the arachnoid is likewise a seat of hemorrhage, owing to its share in the effects of the traumatism, while in spontaneous cortical hemorrhage the meninges are not affected.

According to the violence of the injury will the character of the capillary hemorrhage, destruction of tissue, and corresponding impairment of function vary. The hemorrhage might be disseminated and punctiform, or more pronounced, giving a dark area with lighter boundary. Such a lesion as this, if examined microscopically, would give evidence of minute destruction of cerebral substance by the blood disseminated in the tissues.

If left untreated such a condition will tend toward a process of absorption and gradual restoration of impaired function, provided there is no infection, either directly, because of the traumatism, or indirectly, on account of a latent diathesis which could, perhaps, implant itself in this locality. The minute hemorrhages become encysted and disappear. In other words, should there be no fracture leading to a possible infection from without, nor lurking diathesis leading to an infection from within, these contusions of the brain rarely lead to suppuration or violent encephalitis. (See NERVOUS SYSTEM: ENCEPHALITIS, and CEREBRAL ABSCISS.)

PROGNOSIS.—The prognosis depends altogether upon the presence or absence of infection and the general health of the patient. Should no disturbance be feared from these two causes, a gradual recovery is to be anticipated. On the contrary, should the destruction of brain tissues have become infected, we may expect encephalitis and its results. If the patient survives twenty-four hours recovery is likely to take place, so far as the direct effects of the concussion are concerned.

TREATMENT.—Since the danger from contusion of the brain results from a permanent destruction of function, on the one hand, and infection on the other, the treatment will be directed toward obviating the possibility of these accidents.

Our guide will, therefore, be the violence of the symptoms. Should these indicate no absolute gravity from loss of function, such as complete unconsciousness, great depression, and paralysis, the reaction which the con-

tusion necessarily creates in the cerebral tissues must be met as follows: **Complete rest; head slightly elevated.** The depression must be relieved by hypodermic injections of **strychnine sulphate**, $\frac{1}{40}$ grain (0.0016 Gm.) every three hours until reaction takes place in the pulse. **Hot-water bags** are applied.

As soon as the patient is able to swallow, he should be given **purgatives**, which will, by depleting the circulation, promote the absorption of effused serum following the contusion of the brain.

Should there be the slightest abrasion or wound of the scalp, even if unaccompanied by fracture of the skull, the strictest **antiseptic precautions** should be preserved, lest any infection from without provoke a meningitis.

If the symptoms are much aggravated in a few days, showing cerebral edema, and consequent autocompression of the brain against the skull, the indication then is to **trephine** over the seat of the injury and if necessary **incise** the **dura** for the relief of intrameningeal pressure.

The trephined opening may be enlarged by means of the rongeur forceps, if the size of the contused area warrants the procedure; it is remarkable how much drainage of serum and possibly cerebrospinal fluid takes place under the circumstances, followed by gradual disappearance of the pressure symptoms. The subsequent treatment would then be as in less aggravated cases.

In 397 cases of skull contusions, during the war, the writer found **lumbar puncture** a valuable aid in treatment of severe contusion of the brain or spinal cord from explosion of a shell or mine. The fluid keeps under high

pressure for days and the patients exhibit paralytic phenomena or melancholia with stupor of Jacksonian epilepsy. Leriche (*Lyon Chir.*, Sept., 1915).

SUBDURAL HEMORRHAGE.

This hemorrhage generally occurs from the rupture of a number of small vessels, or of one large vessel (especially the middle cerebral), the extravasation being located under the dura mater.

SYMPTOMS.—The symptoms and treatment are very much the same, the differentiation between this and the preceding variety not having yet been made out.

ETIOLOGY.—This hemorrhage occurs most frequently as a result of depressed fracture. A few cases have been reported as due to pachymeningitis interna, which cases should be treated by trephining, evacuation, and drainage.

PATHOLOGY.—The patient often dies from direct injury to the brain. If he recovers, the clot, having produced more or less paralysis, is gradually absorbed, but the brain may not expand to its former position, being permanently depressed, the site of the injury being sometimes occupied by spongy connective tissue, the meshes of which are filled with cerebrospinal fluid, resembling a series of cysts. The paralysis will gradually lessen and may almost entirely disappear, but, after a period of from a few months up to two or three years, epileptic or other cerebral disturbance may appear and persist throughout life.

TREATMENT.—The treatment is the same as for extradural hemorrhage. The anterior **trephine** opening, already referred to, is enlarged

upward and backward, giving access to the middle cerebral arteries, and, if symptoms indicate intracranial hemorrhage, and no clot is found under the bone on trephining, the dura should be opened and the clot searched for along the fissure of Sylvius, in which the middle cerebral lies, and the bleeding-point must be found, if possible, and the artery tied.

Lumbar puncture advised in traumatic subdural hemorrhage in the newly born. If this fails, a small **decompressive trephining** of the space below the tentorium back of the mastoid process is suggested. Henschen (*Archiv f. klin. Chir.*, Bd. xcix, Nu. 1, 1912).

CEREBRAL HEMORRHAGE.

See CEREBRAL HEMORRHAGE, Vol. III.

COMPRESSION OF THE BRAIN.

This is a not uncommon condition in injuries of the head, arising from various causes. In whatever way this condition is brought about, from the pressure of extravasated blood, of pus or other inflammatory exudate, of a depressed portion of bone from fracture or new growth, or from a foreign body lodged there, the symptoms, although presenting some differences, are, as a rule, constant.

In compression from depressed fracture, foreign bodies, and apoplexy the onset of the symptoms is immediate; in middle meningeal hemorrhage and in inflammatory exudates it is delayed, while in tumors, cysts, and chronic hydrocephalus it is very gradual. The symptoms may be preceded by or mixed with those of concussion in traumatic cases. The degree of pressure when localized determines either irritation or paralysis of the affected center.

In generalized compression the symptoms, when the condition develops gradually, are those of irritation, and, as the pressure increases, those of paralysis of the cortical and lastly the bulbar centers. Headache, vertigo, restlessness, delirium, convulsions, vomiting, tinnitus, contracted pupils, and choked disk mark the first stage, to which are added a slow, full pulse; elevated blood-pressure, rapid and deeper respirations, from stimulation of the vagus, vasomotor, and respiratory centers. Trauma, hemorrhage, and shock lower the temperature; lesions of the pons and medulla and inflammatory conditions raise it.

In the second stage the patient lies in a state of lethargy, stupor, or coma, more or less completely paralyzed, heavy, insensible, and drowsy, either not responding when addressed or only when spoken to in a loud tone of voice, and perhaps only when violently shaken. The respirations are slow and deep, with stertor or snoring, and usually a peculiar blowing sound. Paralysis of the velum palati, which, hanging down as a curtain, is thrown into vibrations during expiration, seems to cause the stertor; the distention of the cheeks and the blowing sound are due to muscular paralysis of the lips and cheeks. The pulse is full and often slow; one or both pupils are dilated; paralysis of the sphincter ani causes involuntary evacuation of the feces, and paralysis of the bladder generally causes retention of the urine; the skin may be cool, but is, in many cases, rather warm and covered with perspiration. Frequently the condition of stupor alternates with paroxysms of delirium or of local convul-

sive action. This condition of coma may become complicated by the appearance of symptoms of inflammation.

Unless the cause that produces the compression is removed, death quickly follows, the coma deepening and the patient dying in an apoplectic condition from respiratory failure, the heart continuing to beat for some minutes after breathing has stopped. In rare cases the coma may continue for many weeks or months, until the cause of compression is removed, when consciousness will return and the symptoms suddenly disappear. The treatment of this condition is obvious.

The writer does not approve the modern tendency to decompress every cerebral injury. In 200 cases 37 per cent. of the fatal ones died within 6 hours or less, and 56 per cent. within the first 12 hours. He does not recall, except in 1 or 2 instances, where operation helped when the case seemed hopeless. Repeated lumbar punctures, however, are advised in these cases. Where consciousness is not lost, or there is mild coma and no grave intracranial trauma is indicated, operation is not advised unless pressure or distinct localizing symptoms supervene. Ransohoff (*Lancet-Clinic*, cxiii, 537, 1915).

As to contraindications for decompression, the writer has never seen a case of acute high intracranial pressure with a pulse of 45 to 50 recover by operation if the case was left unoperated until the pulse on the secondary rise had reached 95. R. L. Payne, Jr. (*Surg., Gynec. and Obstet.*, xxvii, 345, 1918).

TRAUMATIC INTRACRANIAL HEMORRHAGE.

Extravasation of blood commonly occurs in all injuries of the head accompanied by laceration of the brain, and in many in which the skull is

fractured and the brain uninjured. Intracranial hemorrhage is favored by the great vascularity of the parts within the skull, the large sinuses, the numerous arteries that ramify both within the bones and at the base of the brain, and the intricate vascular network extended over the surface of the brain.

The extravasation may occur in three situations: Between the dura mater and the skull (extradural); between the dura mater and the brain (subdural); within the brain substance and its ventricles (cerebral).

EXTRADURAL HEMORRHAGE.

This form of hemorrhage is also called *meningeal extravasation*, as it most commonly arises from rupture of the middle meningeal artery or its branches, which, from its location in a deep canal in the parietal bone, is peculiarly liable to rupture in injuries of the side of the skull.

SYMPTOMS.—The symptoms of extradural hemorrhage are those of compression, divisible into three stages: concussion, a return and some continuance of consciousness (pathognomonic of this condition), and then coma, gradually supervening. The patient is at first stunned by the accident; from this he quickly recovers and then relapses into unconsciousness, which gradually increases in intensity. He becomes dull and sleepy, with a slow, laboring pulse; dilated and sluggish pupils, and a tendency to slower respiration. As the compression increases, complete stupor supervenes, with stertorous breathing, and the appearance of either general paralysis or hemiplegia of the side opposite to the injury.

DIAGNOSIS.—The diagnosis of this and the following (subdural) form of hemorrhage from the *cerebral* form is important, as no operative interference in the latter case would be successfully undertaken, for the reason that the injury to the brain substance is usually so extensive that, even were the clot removed, the patient would die from the injury. Attention to the symptoms of each variety will usually be sufficient to differentiate them.

The diagnosis between compression from *extravasation* and that from *depressed bone* or *inflammatory effusions* within the skull is generally easily made. In depressed fracture the compression symptoms continue uninterruptedly; examination will reveal the injured bone. Compression symptoms due to inflammatory effusions are preceded by symptoms of cerebral inflammation, and are accompanied by a strong febrile movement, accelerated pulse, and hot skin; the character of the scalp wound and the separation of the dura mater when pus is effused distinguish this form from that in which the pressure is the result of extradural or subdural hemorrhage.

From apoplexy differentiation is not easy. From drunkenness, the absence of injury, the odor of the breath, and the flushed and turgid face would point to alcoholic intoxication.

In opium narcosis the pupils are strongly contracted, instead of being widely open, as in coma from cerebral compression.

ETIOLOGY.—Extradural hemorrhage may occur with or without fracture of the skull. When the result of fracture, it is caused by the

fissure tearing across the meningeal artery or more often one of its branches distributed on the interior of the skull, or a fragment of bone wounding a sinus or the vascular network on the cerebral surface.

PATHOLOGY.—The blood that is extravasated usually coagulates into a firm, granular clot. This clot may be absorbed entirely; the serous portions and coloring matter may become absorbed, leaving a fibrinous, buff-colored clot, which may become organized; and finally the exterior of the clot may become organized, while the interior may contain fluid and disintegrated blood.

PROGNOSIS.—The mortality of these cases treated upon the expectant plan (without operation) is very high. Wiesmann reports 147 cases treated expectantly, with 131 (89.1 per cent.) deaths, while, of 110 cases operated on, only 36 (32.7 per cent.) died, and in the majority of the fatal cases the extravasation was not reached and the clot therefore not removed.

TREATMENT.—Operative treatment should be resorted to as soon as the diagnosis has been clearly made. The localizing symptoms should determine the spot to be trephined. Krönlein has shown that, in the greater number of cases, the clot will be most easily reached by **trephining** $1\frac{1}{4}$ inches behind the external angular process at the upper level of the orbit. If the clot is not found by this opening we may trephine just below the parietal boss, on the same level with the former opening. The main trunk and the anterior branch of the middle meningeal artery are reached by the anterior opening, and the posterior branch by the posterior open-

ing. If the clot be discovered it should be removed, enlarging either trephine opening, if necessary, by the rongeur forceps. If the pupil be dilated, showing that the clot is gravitating downward toward the base, the trephine opening should be made near the first point, but about $\frac{1}{2}$ inch lower. After the clot has been scooped out gently, the cavity should be well washed out with freshly boiled water cooled down to blood heat. If the artery is still bleeding, a semicircular Hagedorn needle armed with catgut should be passed through the dura, under the artery, and out again through the dura on the other side of the artery, and the artery tied. **Drainage** should be provided and the wound treated antiseptically. W. W. Keen makes a second trephine opening immediately if the first trephine opening does not answer well for drainage in the recumbent posture.

In extradural hematoma the mortality is 90 per cent. under conservative treatment. After operative measures over 67 per cent. of the patients recover. Improvement in asepsis and trephining technique has much improved the prognosis of traumatic intracranial hemorrhage, especially from injury of the middle meningeal artery. The hematoma can be localized by a Neisser puncture. The blood should be removed after osteoplastic trephining, with finger and spoon and rinsing with salt solution. All cases of epilepsy of pronounced Jacksonian type require surgical intervention. Tumors in the brain can be localized in fully 75 per cent. of all cases (Bruns). Neither lumbar puncture nor Neisser puncture of the brain gives any such results as palliative **trephining**. Küttner (Deut. med. Woch., March, 1909).

In cases of trauma of the skull in which expectant measures are war-

ranted, **lumbar puncture** will reveal intracranial hemorrhage, and by repeated puncture its course can be determined. If, however, there is a varicose tendency the meninges may share in it, and the cerebrospinal fluid be hemorrhagic without any cerebrospinal lesion. Therapeutically, the puncture may induce marked beneficial effects. R. Malatesta (Polí-clinico, May, 1909).

It is difficult and frequently impossible to distinguish clinically epidural from subdural hemorrhage or serous effusion, but each requires **trephining**. Epidural hemorrhages are easily accessible, and the operation for them does not involve much risk. The subdural ones are much more serious, as they involve greater liability of cerebritis and hernia, but these dangers are minimized by strict asepsis and careful closure of the dura. Kakels (Med. Rec., Dec. 4, 1909).

Early surgical interference in skull fracture with intracranial hemorrhage in children will result in almost certain recovery, while delay for months or years can lead only to disappointment. Much improvement may, however, be obtained in children after years' delay. Rogers (Jour. Amer. Med. Assoc., March 4, 1911).

ABSCESS OF CEREBRUM AND CEREBELLUM. See CEREBRAL ABSCESS.

INFECTIVE SINUS THROMBOSIS.

This is usually secondary to infections of the ear, nose, pharynx, face, orbit, or scalp, the primary inflammation spreading by contiguity, or by setting up a phlebitis which extends inward to the sinuses. Middle-ear disease is the cause in two-thirds of the cases and the lateral sinus is the one affected. Primary infection may arise in compound fractures of the skull or in acute infective fevers. Meningitis and brain abscess are frequent complications.

SYMPTOMS.—These arise from the infective fevers and from the thrombosis. The infective symptoms are similar to those of septicemia or more often pyemia; some cases simulate typhoid fever; in others pulmonary symptoms are present, due to infection of the lungs with emboli. If the meninges become infected, there will be cerebral irritation or compression. The thrombotic symptoms vary with the sinus affected. In thrombosis of the *lateral sinus* there are pain, tenderness, and edema along the line of the sinus, over the mastoid and along the jugular, if invaded. There is usually a history of suppurative middle-ear disease with offensive discharge which has ceased with the beginning symptoms of sinus thrombosis. The pneumogastric, glossopharyngeal, and spinal accessory nerves may be paralyzed by pressure in the jugular foramen. In thrombosis of the *superior longitudinal sinus* there are pain, tenderness, and edema along the sinus and over the forehead, epistaxis, and perhaps convulsions from irritation of the motor area. In thrombosis of the *cavernous sinus*, there are exophthalmos, edema of the orbit and eyelids, choked disc, and paralysis of the third, fourth, ophthalmic branch of the fifth and sixth cranial nerves. There are no localizing symptoms in thrombosis of the *petrosal sinus*.

TREATMENT.—In thrombosis of the *lateral sinus* due to middle-ear disease, the **mastoid** should be **opened and cleaned out**, and the **sinus exposed** by gouging or chiseling the bone at the posterior part of the opening. **Remove** any **pus** in the groove of the sinus, and confirm the diagnosis by palpating the sinus and by

aspirating its interior. After confirming the diagnosis the internal jugular vein should be tied below any existing thrombus to prevent septic dissemination. **Open the sinus**; remove the clot with a **curette** until blood flows freely. Gauze forced between the sinus and the bone will control this bleeding. If the jugular is involved excise it above the ligature and irrigate from the opening in the mastoid through to that in the neck. Pack both wounds with **sterile gauze**. The mortality after operation is about 50 per cent.; without operation practically all cases die. Thrombosis of the *longitudinal sinus* is treated in a similar manner; the remaining sinuses are practically inaccessible.

WOUNDS OF THE SINUSES OF THE BRAIN.

The superior longitudinal or the lateral sinuses are occasionally injured during the course of operations, but more often in cases of severe fracture of the skull, usually of the compound variety. When a sinus is injured the extravasation of blood is so rapid and copious that the patient may die in a few minutes from shock, as rapid loss of blood from the brain is more fatal than a like loss in other situations. Hence the necessity for great care when operations are made in the neighborhood of the sinuses. In using the trephine the edge of the instrument should be placed at a perfectly safe distance. The dura may be separated and the sinus entirely detached from the skull by using the dural separator, or a grooved director or probe, and then the finger. The rongeur forceps may then be safely used to enlarge the

opening made by the trephine. If incision or exsection of a portion of the sinus is necessary, the sinus may be exposed and ligated on both sides of the proposed incision or exsection. If the sinus be opened accidentally during operation or by fracture, **lateral ligature** and **suture** of the sinus may be employed, the former being less difficult and dangerous than the latter, but only applicable to small wounds; instant packing with **iodoform gauze** will, however, arrest such hemorrhage. It has also been suggested that the margins of the wound be secured by one or more pairs of **hemostatic forceps**, which may be removed on the second or third day.

INFLAMMATION OF THE BRAIN AND MENINGES.

Intracranial inflammation may involve the dura (pachymeningitis), the arachnoid and pia (leptomeningitis), or the brain (encephalitis). Under this general head we should include infective sinus thrombosis. See also MENINGES AND BRAIN, DISEASES OF.

Pachymeningitis Externa.—Inflammation of the outer layer of the dura mater may be due to trauma, syphilis, or to diseases of the cranial bones, especially the bony tissue enveloping the middle ear. In the *simple* form the dura is thickened and may cause a persistent localized headache. In the *suppurative* form pus collects between the dura and the bone. The symptoms and treatment are those of extradural abscess. See also MENINGES AND BRAIN, DISEASES OF.

Pachymeningitis Interna.—This may be due to extension from the outer layer of the dura or from the pia and arachnoid. When the

vessels of a vascular layer, which forms on the inner surface of the dura, ruptures it is called *pachymeningitis interna hemorrhagica* or *hematoma of the dura mater*. This affection is generally bilateral, and occurs most frequently in the insane, alcoholic, syphilitic, and in the aged, but may complicate infectious fevers and diseases of the blood. The symptoms are those of cerebral irritation and slowly progressing compression, occasionally presenting localizing phenomena. Treatment consists of **trephining** on both sides and **removing** the subdural **clot**. See also MENINGES AND BRAIN, DISEASES OF.

Leptomeningitis.—Inflammation of the pia-arachnoid may be acute or chronic, localized or diffused. The acute form may be primary, due to pyogenic organisms of wounds or to *Diplococcus intracellularis meningitidis* of epidemic cerebrospinal meningitis. Most commonly it is secondary to infective diseases of the scalp, cranium, and face (erysipelas, carbuncle, caries, necrosis, and middle-ear disease), or to pyemia, pneumonia, typhoid, influenza, diphtheria, gonorrhea, anthrax, actinomycosis, tuberculosis, or sun-stroke. It may occur as a terminal infection in many chronic diseases, including chronic alcoholism (pyogenic organisms). The subarachnoid space becomes distended with a cloudy or purulent fluid, and the brain becomes edematous and covered with lymph, and often is the seat of small hemorrhages. The inflammation generally extends to the meninges of the cord. The symptoms in traumatic cases usually appear within two or three days, although they may be delayed as a result of delayed infection by way of

the blood- or lymph- vessels. The symptoms are those of sepsis, of cerebral irritation, and of cerebral pressure. Upon lumbar puncture the cerebrospinal fluid spurts out, being under great pressure; it contains many polymorphonuclear leucocytes in septic cases, many lymphocytes in tuberculous cases, and the specific bacteria of the several causative diseases. **Trephining** for drainage is indicated if the process is localized, the opening being made in the occipital bone at the base of the brain. Chronic leptomeningitis is not infrequently met with in syphilitics and alcoholics, but may also be traumatic in origin. The membranes become thickened and adhere to the brain, giving rise to persistent localized headache, tenderness, and, at times, epilepsy. When medical treatment (**sedatives** and **iodides**) fail **trephining** is indicated. For ENCEPHALITIS, CEREBELLITIS, MENINGITIS, ARACHNITIS, and TUBERCULOUS MENINGITIS, see MENINGES AND BRAIN, DISEASES OF.

FOREIGN BODIES IN THE BRAIN.

As the result of traumatism, bullets, knife-blades, arrowheads, umbrella ferrules, nails, wire, splinters of wood, pipe-stems, fragments of bone, clothing, hair, etc., have been found lodged within the cerebral substance. The symptoms caused by the presence of foreign bodies in the brain are treated of in PENETRATING WOUNDS OF THE SKULL AND BRAIN and GUN-SHOT WOUNDS. The following course of treatment is advised: Gentle **probing** or the use of the **Röntgen rays** to detect the presence and location of the foreign body, no force being used. **Remove** the **fragments** about the

wound of entrance and thoroughly disinfect the latter. Avoid prolonged and elaborate search should the bullet or other foreign body be not readily found. Employ **drainage** and **dress antiseptically**. If there is any bleeding, this can be controlled by a **tampon** of **iodoform gauze**, which will at the same time assist the drainage. After applying the antiseptic dressing apply **cold** to the **head**. If symptoms of encephalitis develop and are not controlled by careful irrigation and dressing, open the jugular vein and **bleed** the patient. Absolute **rest** and quiet should be insisted upon. The **diet** should be light and nutritious, **stimulants** being added, if necessary.

The present consensus is that the ventricles and the base of the brain must still be regarded as regions inaccessible to surgery. Otherwise, the majority seem to agree that cautious extraction of the projectile at once, through the passage made by its entrance, is the preferable procedure. Burger (*Arch. Méd. Belges*, Oct., 1917).

TUMORS OF THE BRAIN.

This section is a revision, by the writer, of the excellent contribution by the late Dr. J. T. Eskridge, of Denver, to the earlier editions of the present work.

SYMPTOMS.—The symptoms of a cerebral tumor vary according to the size of the growth, its location, the rapidity of its development, the age of the patient, the character of the tumor, and the indirect effects on distant portions of the encephalon. These may be classed as general and focal. Usually the former are the first to attract the attention of the patient, but occasionally the manifestations of the latter are the first to

cause him to seek the advice of a physician. The general symptoms are usually headache, intermittent or constant, with periods of exacerbation, going on for weeks or months before dizziness, nausea, and apparently causeless vomiting are complained of; not infrequently disturbance in vision or a general convulsion occurs before or soon after the headache has become severe enough to interfere with the comfort of the patient. In the cases in which focal symptoms have been the first to appear, convulsive movements, limited to a group of muscles, to one limb, or to one side of the body, or symptoms of speech disturbance lead the patient to seek relief. As the disease advances the early symptoms become more marked, and numerous others are added, much to the discomfort and incapacity of the patient. Headache, if not severe before, soon becomes agonizing; vision gradually or rapidly lessens; vomiting often occurs with or without nausea, especially in early morning, when the lesion is situated in the posterior fossa or at the base of the brain, and the patient may become greatly emaciated; sustained mental effort is impossible, both on account of the headache which it usually augments and on account of the mental deterioration resulting from brain disturbance; walking may become difficult or impossible, either from paralysis or from interference with muscular co-ordination, the latter usually being due to a growth in the posterior cerebral fossa, the cerebellum, or in the region of the corpora quadrigemina; there may be disturbances of special and general sensory phenomena. Various respiratory and

circulatory irregularities may be present. Usually the patient becomes stuporous and finally comatose before death takes place. In a few cases convulsions cause death before the patient dies from exhaustion.

Among the general symptoms, headache, double optic neuritis (choked disc), vomiting, vertigo, and general convulsions are the most important.

Headache is often the earliest symptom, and is usually one of the most prominent, constant, and distressing. It is present in from 75 to 95 per cent. Eskridge's experience led him to believe that it is rarely absent throughout the course of the disease. It is less constant and less severe in certain gliomatous growths. It often intermits, and may be absent for prolonged periods, especially while the patient is taking large doses of potassium iodide, although the tumor may not be syphilitic in character. The headache is often agonizing, especially during the periods of its exacerbation. In some cases the pain is so great, especially in subtentorial tumors, as to cause death in a few weeks, or, at most, in a few months, from the time that the headache becomes prominent. It is usually worse at night. In many cases, while the pain is sufficient to interfere with sleep and mental exertion, it is much less intense than in the severer ones. In not a few the pain amounts to little more than an uncomfortable cephalic fullness or tightness, with an occasional exacerbation. The pain may be lancinating, rending, stabbing, dull, heavy, or boring in character. It is usually most severe when the tumor is rapidly growing, when situated at the base

below the tentorium so as to exert pressure on the veins of Galen, or in the cortex; least severe in slowly growing tumors, especially when situated in the centrum ovale. The pain may be increased by anything that augments the blood supply to the brain. It may be diffused or limited to one or more regions of the brain. Its location is no positive indication of the seat of the tumor, except in those cases in which the growth is superficial and involves the membranes, when the pain, and tenderness on percussion, may correspond to the seat of the morbid process. Tumors in the frontal region less frequently give rise to occipital pain than a growth in the posterior portion of the brain causes frontal headache. A persistent occipital or suboccipital pain usually points to a subtentorial growth, and, in these cases, pain often radiates down the posterior cervical region. A tumor in one cerebral hemisphere may give rise to pain in the opposite side of the head and nowhere else; but a unilateral occipital headache usually corresponds to the side of the head on which the growth is situated.

Headache in brain tumor becomes more intense when the patient suddenly changes his position or makes a rapid movement with his head; changes of position may first elicit the headache. Lack or subsidence of headache, however, is no evidence against brain tumor. Slow high-tension pulse and absence of the tendon reflexes are occasionally found as manifestations of high pressure in the brain. An acute onset with rising temperature and frequent fluctuation in the intensity of the clinical picture suggest rather hydrocephalus and serous meningitis than tumor, while a constantly progressive clinical picture speaks for a tumor, although the

latter may be accompanied by hydrocephalus with resulting fluctuation in the symptoms. Bychowski (*Deut. med. Woch.*, March 10, 1910).

Brain tumors cause a constant set of symptoms, namely, a tendency to apathy, mental torpor, forgetfulness, confusion and mental decadence. Superposed on this there may be delirium or stupor. There are no special psychic features in frontal lobe tumors. Borda (*Revista de la Assoc. Med. Argentina*, Dec., 1917).

Choked Disc, Optic Neuritis, and Optic Nerve Atrophy.—Choked disc, or optic neuritis, while not usually an early symptom, occurs in over 80 per cent. of the cases of tumor of the brain. It begins acutely, and only a few days or weeks may elapse from its first appearance until it has reached a degree of considerable intensity. An ophthalmoscopical examination may reveal it while vision is still well preserved. It is usually bilateral, but the morbid process is further advanced in one eye than in the other. When it is unilateral the indications are that the disease is anterior to the optic chiasm. Knies states that "simple neuritis, terminating in atrophy, is found less often than choked disc in cerebral tumors." According to this writer, it happens in tumors of the frontal lobe in which the tumor is close to the optic nerve. In all such cases the disc is choked to a greater or less extent, and when the stage of atrophy has set in the sinuosity of the vessels near the disc will be the only means by which to determine the secondary nature of the atrophied nerve. Primary atrophy of the optic nerve probably does not occur as a result of tumor of the brain.

Choked disc is probably due to distention of the sheath of Schwalbe by obstructed cerebrospinal fluid, result-

ing in the edema of the nerve head, which necessarily leads to stasis of the veins. Toxic elements play an insignificant part. A small, benign, slowly growing, and remote tumor so situated as to cause hydrocephalus—for example, by pressure on the iter—can lead to a high grade of choked disc, whereas a malignant, rapidly growing glioma, which causes but little pressure, owing to the way in which it infiltrates the brain, may produce no change whatsoever, even though situated near the optic nerve. James Bordley, Jr., and H. Cushing (*Jour. Amer. Med. Assoc.*, Jan. 30, 1909).

Choked disc seems to occur less frequently in tumors of the medulla, and of the centrum ovale of the middle and anterior portions of the brain; most frequently when the growth is situated in the cerebellum, the corpus callosum, the corpora quadrigemina, and the great ganglia, or at the base of the brain.

Vomiting, a frequent symptom of tumor of the brain, occurs most commonly when the growth is large and rapidly growing, situated in the cerebellum near the middle lobe or in the neighborhood of the corpora quadrigemina. It is a prominent symptom in about one-half the cases, often associated with severe headache, and may be projectile in character, and not associated with taking food or with nausea. When the growth is so situated as to affect the middle lobe of the cerebellum or corpora quadrigemina, vomiting may be produced by any sudden movement of the patient's head. Vertigo in many cases is unassociated with vomiting, but it may be a very annoying symptom, and almost constant, yet unattended by vomiting. Like the latter, it is most frequent in tumors of the cere-

bellum and adjacent parts. A general convulsion may precede other symptoms or it may occur at any stage of the disease. It is found in about one-third of the cases, and denotes active progress of the disease. General convulsions rapidly following each other late in the disease may prove fatal. Mental disturbance, insomnia, somnolence, and syncope are found in many cases.

Focal symptoms may be direct and result from the invasion of a portion of the brain by the growth, or indirect and due to its interfering with the function of structures more or less distant from the tumor. Both sets of symptoms are frequently present and prominent at the same time, requiring great care to separate the one from the other.

Incomplete hemiplegia, monoplegia, limited convulsive movements (Jacksonian epilepsy), paralysis or spasm of single muscles or groups of muscles, and contraction are the local disturbances in motility that may result from tumor of the brain. There may be, also, various perversions of the sensory phenomena, hemianopsia, and aphasia, depending upon the seat of the growth.

The **course and duration** of intracranial growths are variable, depending upon the character of the tumor, its location, and the complications. The symptoms are usually gradual in their development, in a few rapid, and in others they are arrested for several months. Some tuberculous growths may apparently run their course in a few weeks on account of the presence of meningitis, while others extend over a period of years. In a few cases, after a growth has gradually progressed several months

or a year without any very alarming symptoms, death may suddenly occur with symptoms of a vascular lesion. The average duration of tumor of the brain is about fifteen months, but the variation is from a few months to two or three years, or even a greater length of time.

In the majority of cases of cerebral tumor there is a syndrome of endocranial hypertension which varies with the nature, localization, and development of the tumor. Evolution without signs of hypertension occurs mainly in cases of glioma, angioma, or hard sarcoma. Hypertension is early and intense in tumors of the posterior cranial fossa. Headache, amblyopia, vomiting and vertigo are the cardinal symptoms. The first 2 symptoms are the most constant. Headache is of little value, but amblyopia may be of diagnostic value. It is early and intense in the case of basal tumors and those of the posterior fossa; it may be absent or very slight in frontal and parietal tumors. Castex (Rev. Assoc. med. argent., xxvii, 770, 1917).

DIAGNOSIS.—The first problem for the diagnostician to solve in a case is: Are the symptoms due to organic intracranial disease? When an organic lesion develops in a nervous subject, symptoms, functional in character, will be added to those of organic disease. Hysteria and organic disease are not infrequently found in the same subject at the same time. A multiplicity of symptoms pointing to hysteria is of less importance in enabling one to make a diagnosis than the presence of one symptom organic in origin. As a rule, symptoms that are usually regarded as organic when caused by functional disturbance are temporary and fleeting in character; and the opposite, while true in the vast majority of cases, finds a notable exception in

multiple sclerosis of the central nervous system. Marked muscular wasting in the distal portion of a paralyzed limb of cerebral origin, associated with flexor contracture and decided increase of the deep reflexes over those of the corresponding limb of the opposite side; most cases of crossed paralysis or pronounced trophic disturbance in one or both eyes, of cerebral origin; more than transient lateral homonymous hemianopsia or sensory aphasia, may be regarded, in the vast majority of cases, of organic origin, although only one of these conditions exists. There are other and more frequent symptoms which are always very strong evidence of organic brain disease, but not positive proof of it. Among these the first in importance is optic neuritis, or choked disc. The latter may be due to tumor, renal disease, lead encephalopathy, or pronounced anemia. The first condition named produces much more swelling of the disc than is found resulting from any of the last three; besides, in the latter, there are evidences of either renal disease, lead poisoning, or anemia. Intraventricular effusion or abscess of the brain may cause choked disc, but these diseases have their distinct symptoms. It must be borne in mind that organic brain disease may be present in a person suffering from disease of the kidneys, lead poisoning, or anemia. Under such circumstances a careful analysis of the symptoms and a study of the case will enable the physician to determine the nature of the case. Persistent headache, obstinate vomiting, and vertigo are frequent symptoms of intracranial growths, but they rarely continue long unassociated

with eye changes, except possibly in tumors of the medulla. Paralysis or spasm of the ocular muscles, rapid in its development, and facial paralysis, not extracranial in origin, are usually due to organic brain disease. In hemiplegia of organic origin the deep reflexes of the paralyzed side are greatly in excess of those on the non-affected side. This is not so in hysteria. Hemianesthesia, including the special senses, as observed by Gowers, "is one of the rarest effects of cerebral tumors, and is absolutely unknown from this cause unless associated with loss of motor power." Whether it occurs from tumor or other forms of organic brain disease, affecting the posterior portion of the internal capsule, the lateral hemianopsia, homonymous in character, will differ from the "crossed amblyopia" sometimes seen in hysteria. Persistent sensory aphasia is probably almost always due to an organic brain lesion. Convulsions, general or local, must be seen and carefully observed by an intelligent nurse before the true nature can be determined by the physician. It is well to bear in mind that a febrile condition simulating—by its periodicity—malaria may occur in the course of organic disease of the brain, especially in connection with abscess, tumor attended by rapid softening of the surrounding substance, tuberculosis, and possibly syphilis.

The commonest mistake in cerebral tumor is, perhaps, to diagnose hysteria. Formerly there was some excuse for this. But we know now that inverted color fields is a sign not of hysteria, but of increased intracranial tension, and that hysterical anesthesia is induced, evanescent, and easily removable. The hysterogenetic zones are merely the normal erethistic

areas which most easily provoke instinctive defense reactions, or may be the artefacts of suggestion. Contractures and palsies are now also clearly comprehended as direct or indirect results of suggestion.

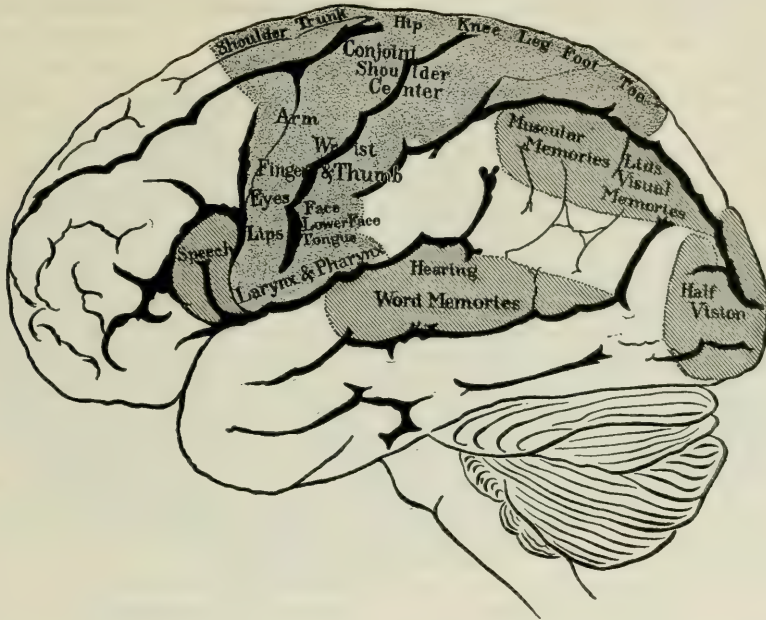
Again, the deep reflexes are not in reality modified hysterically, although here two qualifications must be mentioned: 1. By imitative suggestion, a reflex may appear to be modified, but it is not difficult as a rule to detect intentional interference of the patient: 2. Systemic states interfering with the nutrition of the neurons often modify reflex responses, sometimes unequally in different parts of the body. Such toxic states very often also increase the patient's suggestibility. T. A. Williams. (*Archives of Diag.*, Oct., 1911).

Having satisfied ourselves that organic disease of the brain is present, the next question to determine is: Is it tumor? It is rare that tuberculous meningitis is likely to be mistaken for tumor, except possibly in those cases which run a prolonged course. These are often attended with tuberculous nodules or even a tuberculous growth of considerable size. Under such circumstances the symptoms will partake of the character of meningitis and intracranial tumor, those of the latter predominating when the growth is large, and those of the former when the deposits are small. In those cases in which a tumor has existed prior to the development of meningitis, not infrequently a history of attacks of apparently causeless vomiting, attended with severe headache, may be obtained. Aneurism is diagnosed by detecting a bruit. The principal symptoms of chronic cerebritis are headache, vomiting, and distinct optic neuritis, without localizing symptoms. This condition probably can-

not be distinguished from tumor of the brain unattended by focal symptoms and pronounced choking of the discs. Chronic hydrocephalus with effusion into both lateral ventricles need not be mistaken for tumor if the symptoms of each are borne in mind and the history of the case is carefully studied. Distention of one lateral ventricle with pronounced unilateral choked disc was mistaken by me for tumor in a case in which the history was unobtainable. A syphilitic meningitis or a nodular tuberculous condition of the meninges attended with great thickening of the membranes to such an extent as to give rise to distinct focal symptoms is clinically indistinguishable from an intracranial tumor. Alcoholic meningitis usually affects the convexity, and tremor is present. One needs only to be familiar with the delusions of grandeur, the character of the mental failure, and other symptoms common to parietic dementia to prevent his confounding it with tumor of the brain. The same may be said of the other forms of insanity, especially mania. In multiple sclerosis the tremor is bilateral; in tumor with tremor the latter is usually unilateral. The atypical symptoms of hysteria and parietic dementia often found in diffuse sclerosis of the cerebrum will aid in preventing this disease from being mistaken for tumor. In diffuse sclerosis if the cerebellum is affected and there is staggering gait, with a tendency to fall to one side, the absence of severe headache, optic neuritis, and vomiting will be against tumor and in favor of diffuse sclerosis. Chronic abscess of the brain does not cause total blindness or marked choking of the optic discs.

Report of 2 cases of "pseudo-tumors" in the brain. The first patient had inherited syphilis; at 23 a subacute meningeal syndrome developed with amaurosis, but very slowly all the symptoms subsided and after three or four years there was none left except that vision never returned in one eye. Exophthalmic goiter developed later. In the second case the symptoms gradually sub-

The mental symptoms are the most constant, but these are variable. The patients may be apathetic, disregard the ordinary proprieties of life, and become filthy and partially demented as the disease progresses. Some exhibit a childishness foreign to their nature, and talk much of trivial things, especially when these relate



Brain, left hemisphere. (Dana.)

sided in the course of two years, except the amaurosis, which persisted. F. Raymond (*Presse méd.*, March 9, 1910).

What is the seat of the tumor? If the tumor is in the premotor region of the **frontal lobe**, there may be few positive focal symptoms. Headache is rarely so agonizing, vomiting so constant, or choked disc so frequent as in tumors in the posterior portion of the brain. My experience has been that choked disc is absent in about one-half the cases of tumor of the premotor region of the frontal lobes.

to themselves; others are irritable, impatient, and at times may show a maniacal tendency; while nearly all manifest a lessened power of sustained attention and mental concentration, with absent-mindedness and lack of judgment. Amnesia is rarely complete unless the tumor is very large or both lobes are involved. If the tumor extends backward motor symptoms become manifest, and disturbances of speech are added in lesions of the left side in right-handed persons. Ataxia of the cerebellar

type has been observed by a few in tumors of the frontal lobe.

Report of 3 cases of frontal tumor. Vague mental symptoms were present in all. One case showed symptoms not unlike those of profound cerebral exhaustion or beginning paresis. Headache was never a marked feature, existing only for a short time before death; vomiting occurred but once, and there was no optic neuritis or involvement of the visual fields. The only suggestive symptom was one attack of slight twitching of the left leg, without loss of consciousness. Occasionally psychic vesical incontinence was present. In another case, with early headache, optic neuritis, and vomiting, there were typical areas of hysterical hyperesthesia under both breasts and over both groins, as well as hyperesthesia over the left parietal region. Left hemiparesis, present for a time only, may also have been hysterical in origin. F. X. Dercum (*Jour. Nerv. and Ment. Dis.*, Aug., 1910).

Tumors in the Rolandic, or so-called motor, region usually give rise to definite localizing symptoms. In the irritative stage of tumors of the cortex, there are Jacksonian epilepsy, involving the muscles of the face, arm, or leg, according to the seat of the growth, and sensory disturbance, often in the form of auræ and numb or tingling sensations, limited to the regions involved in the convulsive movements. After the lesion becomes destructive in character, weakness or paralysis of the affected muscles takes place. As a rule, after every Jacksonian convulsion, the muscles involved in this are weak or paralyzed for a short time. The muscles first affected in the convulsion are the last to cease jerking, are the weakest, and denote the seat of the irritation in the brain. It is important to study the initial phe-

nomena and the order in which one group of muscles after another is involved by the convulsion, as these afford aid in localizing the primary seat of the brain lesion, especially early in the history of the disease. In some cases, probably those in which the irritation is limited to the cortex, the seizure may, for a time, consist of pain, numbness, or tingling sensations, limited to the distal portion of an extremity, or these may immediately precede a convulsive movement, which always begins in the part in which the sensory disturbance is first felt. When the convulsion begins in, or decidedly affects, the muscles of the lower face on either side, but most pronounced when the right is involved, temporary motor aphasia often follows the attack. Some subjective sensory loss, in the distal portion of the limb, is common in tumors of the motor cortex. According to Dana, the sense of localization is most affected.

Tumors of the parietal region may or may not give rise to localizing symptoms, depending upon their size and the involvement of certain structures. It is thought by some that muscular sense is affected by a lesion in the supramarginal convolution. On the left side in right-handed persons, or on the right side in left-handed ones, a growth affecting the angular gyrus or inferior parietal lobule produces word-blindness. If the optic radiations are encroached upon by the tumor, lateral homonymous hemianopsia will be present.

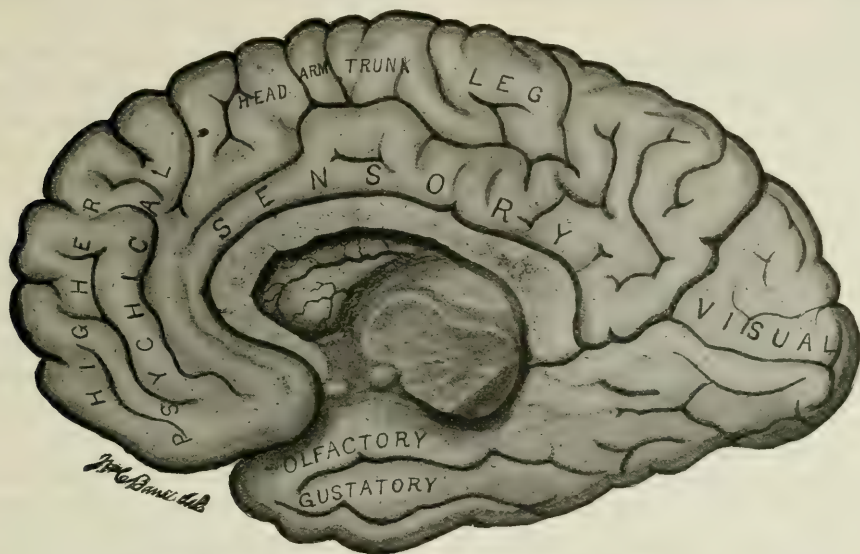
Tumors of the occipital lobe affecting the cuneus or optic radiations will cause lateral homonymous hemianopsia, the blind fields being on the side opposite to that of the lesion.

Mind-blindness has been observed in connection with growths in the left occipital lobe, especially near its anterior portion.

Tumors of the temporosphenoidal lobe may give rise to no focal symptoms, when they are situated on the right side. On the left side word-deafness will result if the posterior portions of the first and second convolutions are affected. When the an-

the corpora quadrigemina by the absence of oculomotor symptoms until late in the disease, and from growths in the cerebellum by the cranial nerves of the bulb escaping.

Tumors of the great ganglia give rise to no focal symptoms until the internal capsule is affected either directly or indirectly. Complete hemianesthesia from tumor in the basal ganglia practically does not occur



Median aspect of the right hemisphere, showing cortical centers.

terior portion of the lobe is involved near the base on either side, disturbances in smell and taste may be present.

Tumors of the corpus callosum may cause general symptoms of intracranial pressure, and, later, hemiparesis, or bilateral weakness, with rigidity of the muscles of the trunk and legs, and often ataxia of the cerebellar type. The disturbances are usually more marked on one side than on the other, and the legs are affected to a greater degree than the arms. Tumors of this region with ataxia are distinguished from those of

without motor defect. When the hemianesthesia is complete, all the special senses may be lessened or lost on the anesthetic side, the visual defect being lateral homonymous hemianopsia, with the blind fields on the side corresponding to the affected side of the body.

Athetoid movements and marked inco-ordination, chiefly affecting the hand, have been observed in lesions of the thalamus. A tremor which is similar in character to that of multiple sclerosis has occurred from tumor in this region, but it is always unilateral.

Tumors of the corpora quadrigemina, besides the general symptoms, such as headache, double choked disc, and vomiting, cause ataxia and incomplete ophthalmoplegia. The ataxia is similar to that observed in lesions of the middle lobe of the cerebellum. Bruns states that the ophthalmoplegia will precede the ataxia when the lesion is in the corpora quadrigemina, but the ataxia will precede the former when the tumor is in the cerebellum.

Tumors of the crus produce "crossed paralysis," hemiplegia on the opposite side of the body,—including the limbs and lower side of the face,—and paralysis of the third nerve on the side on which the tumor is located. Hemianesthesia will be present on the hemiplegic side if the fibers on the upper or posterior portion of the crus are involved. If the optic tract is seriously affected, lateral homonymous hemianopsia will be present, and the pupils will not react to light thrown into the eyes from the side of the blind fields (the hemiopic pupillary reflex of Wernicke).

Tumors of the pons give rise to distinct, but variable, symptoms, depending upon the size and exact location of the growth. A tumor may be situated to one side of the pons and cause decided pontile symptoms from direct pressure, and if the pons is pushed to one side, against the bony structure, as not infrequently happens, the indirect pressure symptoms on the opposite side of the pons from the seat of the tumor may be very pronounced. If the tumor is situated in the upper portion of the pons, on one side there will be "crossed paralysis," and possibly hemianesthesia, as

in tumor of the crus. During the irritative stage of the sixth nerve, the eyes may be spasmodically jerked toward the side of the lesion; but when this nerve is paralyzed, conjugate deviation of the eyes will be to the opposite side. The symptoms from a tumor in the upper portion of the pons on one side—if from diffusion of irritation the sensory tract on the opposite side is not affected—would be conjugate deviation of the eyes to the opposite side, weakness or paralysis, and disturbances of sensation throughout the entire opposite side of body, head, and face. Owing, however, to the diffuse character of the symptoms, both direct and indirect from tumor of the upper portion of the pons, the symptoms are more likely to be dilatation of the pupils, ptosis; strabismus, at times; sometimes cloudiness and ulceration of the cornea; pain, with hyperesthesia and anesthesia in the region of the distribution of the fifth nerve on side corresponding to that of the tumor, and hemiplegia and hemianesthesia of the opposite side of the body and face, the latter if the lesion extends deep in the substance of the pons, often in the form of dissociation of sensory symptoms (loss of pain and temperature sensations; tactile preserved) and loss of conjugate movement of the eyes toward the side of the lesion. Other cranial nerves would probably be affected as the disease progressed. A tumor situated in the lower half of the pons on one side would give rise to crossed motor and sensory paralysis; the face, both the lower and upper on the side of the lesion; the body and limbs, on the opposite side. Marked trophic disturbances usually occur through the

distribution of the affected fifth cranial nerve. Articulation, deglutition, and respiration become affected in lesions of the extreme lower portion of the pons from the involvement of other cranial nerves. As a rule, these are late symptoms in the course of the disease. Tumors lying between the pons and dura often cause bilateral symptoms on account of the cord being pushed against the bony structure. They differ from those caused by tumors within the pons in being more irritative and less destructive in character until late in the course of these growths, and cranial nerve symptoms precede those of the pons.

Glycosuria and albuminuria may occur, giddiness is often intense, and vomiting troublesome if the middle peduncle of the pons is involved. The tumor may directly affect both sides of the pons and produce bilateral symptoms. The knee-jerks are as frequently absent as present, and are extremely variable: present and exaggerated at one time, normal or absent at another.

Tumors of the medulla at first may give rise to unilateral symptoms, but these soon become bilateral, and are somewhat similar to those of progressive bulbar paralysis, except that sensory as well as motor fibers are affected in the former. It must not be forgotten that an intradural tumor of the medulla gives rise to bilateral symptoms on account of the displacement of the medulla to one side against the foramen magnum.

Case in which a sarcoma as large as a walnut was found in the medulla oblongata, entailing inflammation and atrophy of the cerebellum. The main complaints had been difficulty in swallowing and pain in the back of

the neck. The first symptoms had been observed four years before. The velum was paralyzed and a sudden attack of dyspnea developed, in which the patient succumbed. In a second case death occurred suddenly after a weak or so of symptoms diagnosed in the hospital as cerebrospinal meningitis. In 92 cases of tumors in the medulla oblongata on record they proved to be sarcomas in only 17 instances. These patients were between the ages of 25 and 40, mostly women, and the tumor was primary, without metastasis. Such tumors compress and destroy the nervous elements, but remain well circumscribed. The first signs of trouble come on abruptly and the syndrome develops by repeated exacerbations, death occurring generally suddenly from action on the cardiorespiratory centers. Secondary hemorrhages are apt to occur in the growth. The profound destruction and successive involvement of the different bulbar nuclei induce a clinical picture very different from that of glioma; this wealth and multiplicity of the symptoms give the clue to the nature of the tumor (sarcoma), no other tumor in the medulla revealing its presence so unmistakably. Claude and Chabrol (*Jour. Amer. Med. Assoc.*, from *Arch. gén. de méd.*, Dec., 1910).

Tumors of the cerebellum cause well-marked general symptoms, such as headache, double choked discs, vomiting, and often dizziness. Focal symptoms, however, will be entirely wanting if the tumor is not very large and situated in one hemisphere, especially in its posterior portion, so as not to affect the functions of the middle lobe or those of the pons. The most reliable and constant symptoms of a growth affecting the middle lobe are the disturbed muscular movements, the cranial nerve symptoms, and the subjective sensations of insecurity, both while standing and lying. The inco-ordination of mus-

cular movements is most pronounced in the legs, next in the trunk, and least in the arms. The patient's gait is similar to that of a drunken person, the feet well separated laterally in standing and walking, and the body is often thrown to one side, forward, or backward by forced muscular movements. There is no paralysis of legs or arms, unless the fibers in the pyramidal tracts are affected, and no anesthesia. The patient has a sense of insecurity of his position, especially while standing, and this is sometimes complained of when he is lying in bed. If the tumor is situated well forward and in the median portion of the middle lobe, the cranial nerve symptoms will be bilateral; if to one side they will either be unilateral or, at least, most marked on the side corresponding to the tumor. The facial, auditory, and sixth nerves are most commonly affected. The ophthalmoplegic symptoms observed in tumors of the cerebellum affecting the superior peduncles appear secondary to the inco-ordination; when they are due to a tumor in the corpora quadrigemina they precede the ataxia.

The signs on which one can most rely to determine the side of the lesion in cerebellar tumor are as follows: The ataxia, hypotonia, and cerebellar paresis are invariably most marked on, and often confined to, the side of the tumor. The movements of the nystagmus are slower and have a wider range in the direction of the lesion than in the opposite direction. The homolateral arm is held extended more steadily than the contralateral one. Lastly, when the patient is rotated in a chair and the movement is suddenly stopped, the sense of subjective rotation is less intense and the succeeding eye deviation and nystagmus are less marked when the

chair has been rotated toward the affected side than toward the other. As elsewhere in localization diagnoses, however, care should be taken not to lay excessive stress on any single symptom, but to attach different standards of value to the different symptoms and then make a diagnosis on the general clinical picture. E. Jones (*Can. Jour. of Med. and Surg.*, June, 1910).

A patient had marked bilateral optic neuritis. The visual fields were normal. Smell, taste, and hearing were acute on both sides. There was doubtful unsteadiness of the right hand on touching the nose. The gait was reeling and unsteady, the patient lurching to the right, and the right leg was more unsteady than the left on touching the opposite knee. These phenomena led to a diagnosis of right-sided cerebellar lesion, which was confirmed at operation. Stewart (*Brit. Med. Jour.*, Oct. 22, 1910).

Combination of nystagmus with weakening of the corneal reflex points with great certainty to a lesion near the vermis of the cerebellum. Report of a case in which the larger part of the vermis and neighboring portions of the cerebellar hemispheres had to be excised. The resulting defect had not the slightest influence upon the cerebellar functions. H. Oppenheim (*Berl. klin. Woch.*, Dec. 9, 1912).

Tumors of the base strictly limited to the anterior fossa would affect the olfactory nerves, but by extending backward into the middle fossa they may cause unilateral loss of sight or some form of hemianopsia. Mental symptoms are usually present on account of pressure on the anterior lobes. A tumor in the middle fossa, if situated near the sphenoidal fissure, may paralyze all the motor nerves to one eye and compress the first division of the fifth, causing unilateral ophthalmoplegia, anesthesia, and pain in the region of distribution

of this division of the trigeminal nerve, together with trophic changes in the eye. The Gasserian ganglion and all the divisions of the fifth nerve—as well as the second, third, fourth, and sixth nerves—are exposed to the invasion of tumors in the middle fossa. Tumors of the posterior fossa injure the cranial nerves, pons, and medulla, and give rise to many of the symptoms of tumor of the pons and medulla, with these differences: that tumors in this fossa affect the nerves before they do the pons or medulla; in paralysis of the sixth nerve from injury to its trunk the conjugate fibers of the internal rectus of the other eye are not affected, as in nuclear paralysis of this nerve, and the seventh and eighth nerves are usually involved by the same lesion, as they all lie near together at the base.

Case of tumor of the cerebellopontine angle in which the diagnosis was erroneously made of neuralgia and several operations performed for removal of parts of the Gasserian ganglion and nerve section without effect. The tumor was discovered on autopsy. It was a slowly growing sarcoma, which at first pressed on the sensory fifth-nerve root, causing the neuralgic symptoms, while the later symptoms were found referable to irritation of the ninth or glossopharyngeal nerve and had never been properly diagnosed. The sensory distribution of these two nerves is intermingled and irritation of one may possibly cause pains referred to the other. The case showed none of the so-called pressure symptoms. T. H. Weisenburg (*Jour. Amer. Med. Assoc.*, May 14, 1910).

Case in which a neurofibroma in the cerebellopontine angle produced paralysis of the sense of taste in regions innervated by the intermedius. B. Scholz (*Mitteil. a. d. Grenzgeb. d. Med. u. Chir.*, Bd. xxiii, Nu. 4, 1911).

Discussion of 9 cases of colloid tumor of the third ventricle attached to the choroid plexus. The symptoms do not differ from those of any intraventricular tumor of different structure but similar location, but the author believes that an effort should be made to secure an accurate diagnosis of the colloid tumors, as it seems probable that ventricular puncture with free removal of fluid would give temporary relief. There is also a possibility of removing the tumor, or of establishing a permanent communication between the lateral ventricles and the subarachnoid space. The tumor produces its symptoms—headache and restlessness followed by stupor—by obstruction to the veins of Galen and the foramen of Monro, becoming wedged in the anterior end of the third ventricle. A. J. Hall (*Lancet*, Jan. 11, 1913).

MULTIPLE TUMORS.—According to Dana, about one-seventh of all brain tumors are multiple. The tuberculous, cancerous, and melanotic varieties are most commonly multiple. I have found seven tuberculous nodules of considerable size in one brain, situated in widely different portions of the brain.

In only a comparatively small number of cases is it possible to determine the exact nature of the growth, and often the conclusion at which one arrives is little more than a shrewd guess. Secondary growths in the brain usually are of the same nature as the primary one in other portions of the body. Evidences of syphilis or tuberculosis in a person suffering from tumor of the brain point to the probable nature of the growth. Inherited syphilis very rarely gives rise to tumor of the brain. The most common cerebral growths in children are the tuberculous, and these may occur in child-

hood without the signs of tuberculosis in other portions of the body. The cerebellum, comparatively speaking, is remarkably exempt from syphilitic tumors, but the tuberculous and the gliomatous are the most frequent here. Growths in the cortex are usually syphilitic, tuberculous, or sarcomatous. Gliomata and sarcomata frequently occur in the centrum ovale, and may subsequently involve the cortex. The symptoms of most growths of the brain are at first favorably modified by active anti-syphilitic treatment. If the improvement is very great and can be maintained by such treatment, it is strong evidence in favor of the syphilitic nature of the growth.

ETIOLOGY.—Predisposing Causes.—Cerebral growths may occur at any time of life. The third decade furnishes the largest number, about 20 per cent.; the first and fourth about 18.5 per cent. each, and the second and fifth about 14 per cent. each. They are rare in extreme old age. Steffen has reported a case of tumor of the brain in an infant four weeks old.

The character of the tumor varies considerably with the different periods of life. Tuberculous, cystic, gliomatous, and sarcomatous varieties are frequent in childhood and early adult life, the tuberculous largely predominating in childhood. Syphilitic growths are most common in young and middle-aged adults. The gliomatous, sarcomatous, and gliosarcomatous are most frequent during the latter period. In my experience I have found cystic growths much more frequent in adults than in childhood, although this is contrary to the results obtained from a

study of tabular statistics. Carcinomatous growths are found most commonly during the degenerative period of life.

Sex.—After the age of 50 tumor of the brain is found with about equal frequency in the two sexes, but before this time, not excluding early childhood, the male sex suffers nearly twice as often as the female. It seems, then, that the explanation for the increased liability of the male sex to suffer from tumor of the brain must be sought in conditions pertaining to the developmental and active periods of sexual life.

Heredity.—It is still doubtful whether hereditary influences, excluding the tuberculous and the carcinomatous, play any part in the causation of tumors of the brain.

It is probable that worry, anxiety, excessive alcoholic indulgence, cerebral congestion, and depressed states of the nervous system favor the development of cerebral growths in tuberculous and syphilitic subjects, and they favor the formation of cancerous growths in other portions of the body and secondarily in the brain in certain persons, especially those who are the offspring of families in which the history of cancer is found.

Exciting Causes.—There is apparently a direct relation between injury of the brain and the development of tumor in only a few instances. It appears from the study of numerous cases that this relation is frequently overestimated.

Reviewing the literature on tumors of the brain, by far the greater number of tumors were found in the frontoparietal lobes, constituting about 40 per cent., while about 9 per cent. were found in the pons. Nearly 50 per cent. of all tumors found were

gliomata, while only 8 per cent. were sarcomata. Some forms of glioma, however, are indistinguishable from sarcoma, while others show evidence of sarcomatous infiltration, thus forming a combination of the two.

In no case was there any evidence of hereditary tendency, but in a large percentage there was history of an injury to the head previous to the manifestations of the first symptoms. Lesions of the pons are especially diverse in their symptomatology, owing to the complex relations of this structure. The most characteristic symptom of lesions in it is crossed paralysis. The author reports 2 cases showing a marked difference in the clinical manifestations, though the post-mortem sections revealed a nearly total destruction of the entire pons in both instances. W. H. Bodenshtab (*Journal-Lancet*, Sept. 15, 1913).

Syphilis and tuberculosis are two of the most potent causes of tumors of the brain. I have no doubt that the time will come when we shall be able to attribute the origin of many tumors of the brain to micro-organisms.

Knowledge of the functions of the regions of the infundibulum and third ventricle is still very scant. A case which came to autopsy, showing a tumor limited to the lower part of the third ventricle and the infundibulum led the writers to conclude that clinical findings in man show that lesions of the third ventricle region may be accompanied by sensory disturbances, deep disturbances of the circulation and of the mechanism of hydration in the tissues. Claude and l'Hermitte (*Presse méd.*, p. 417, 1917).

PATHOLOGY.—According to Gowers, about four-fifths of the non-syphilitic tumors of the brain are either tuberculous or sarcomatous (including the gliomatous). It is difficult to determine the frequency of syphilitic tumors of the brain, as

so many cases yield temporarily or permanently to antisyphilitic treatment, and are lost sight of by the observer. The difficulty is still further enhanced from the fact that many cases of non-syphilitic tumors temporarily yield to antisyphilitic treatment, and may pass from under the physician's observations before their true nature is determined. The gliomata are found only in the central nervous system and in the retina, and occur far more frequently in the brain than in the cord.

From a study of Starr's tables, consisting of an analysis of 300 cases of tumor of the brain in children, in nearly one-half the tumor was found in the cerebellum, pons, and medulla, while in the same number in the adult only a little more than one-fifth were located in this portion of the brain and its stem. The cerebellum in childhood appears to be a little more than twice as often the seat of tumor as in adult life, but in adults the cortex of the cerebrum is the seat of tumors six times as often as in childhood. From a study of the location of tumors it will be found that portions of the brain inaccessible to the surgeon's knife are much more commonly the seat of growths in children than in adults.

Case of a child of 9, with mild skull injury six years earlier, in which attacks of headache, vomiting, and vertigo and choked discs appeared after the age of 4. In a recent attack consciousness was retained and there was only slight hemiparesis. A loud systolic murmur was heard over the skull, most pronounced over the right ear. The arteries to the brain were dilated, especially on the right side, and there was a mass of dilated veins at the outer border of the right orbit. The diagnosis was facilitated by a

radiogram, which revealed the circulatory anomalies. Improvement occurred after ligation of the right common carotid. The case was one of cerebral plexiform angioma. Isenschmid (Münch. med. Woch., Jan. 30, Feb. 6 and 13, 1912).

Tuberculous growths are the most frequent of brain tumors, especially in childhood, and their most common seat is in the cerebellum or other structures in the posterior cerebral fossa. In nearly one-half the cases the growths are multiple, and give rise to a confusion of symptoms, especially in relation to localization. Syphilitic growths, which are often accompanied by endarteritis or a low form of meningitis, affect the cerebrum much more frequently than the cerebellum, and are found on the surface, either at the base or on the convex surfaces of the frontal lobe and the convolutions near the fissure of Rolando. Gliomata and sarcomata are frequent forms of tumor of the brain. The former grow from the neuroglial tissue, infiltrate the surrounding portions of the brain, may be of considerable size, and are often scarcely distinguishable from the adjacent brain substance; the latter develop from the connective tissue of the membranes and vessels, and are frequently capsulated.

Endothelioma should be borne in mind in cases with increasing cerebral symptoms, such as epileptiform attacks, while the eye-grounds and intellect remain clear. Headache and vomiting are slight or absent, and the general condition good. These tumors spring from the endothelium of the dura and gradually displace brain substance without destroying it, excepting very superficially in certain cases. They are not malignant, and have no tendency to local recurrence or metastasis, though not

encapsulated. G. L. Walton and J. Homans (Boston Med. and Surg. Jour., June 27, 1912).

Case of tumor in a man of 60 which had destroyed nearly all the white matter of the right hemisphere from the frontal pole to the occipital pole. The sense of smell was lost but not vision. The absence of epilepsy indicated a subcortical site. The ataxia had not been accompanied by vomiting or other cerebellar symptoms. Xavier (Annaes Paulistas de Med. e Cir., Aug., 1917).

Brain tumors are frequent in Argentina. The subjects are usually adolescents or adults under 40. The laboratory tests for syphilis, etc., are so unreliable with a brain tumor that the writer now pays little heed to them, basing the diagnosis on the clinical examination and the history of the case. Castex (Revista de la Asoc. Med. Argentina, Dec., 1917).

PROGNOSIS.—The tuberculous in children and the gummatous growths in young adults give the most favorable prognosis. In rare instances a sarcomatous growth may become capsulated and cease to grow or even decrease in size. The duration of life in tumors of the brain varies from a few months to two or three years. In exceptional cases life is prolonged for many years.

Because of great improvement in the technique of brain surgery there are few cases of brain tumor that one would hesitate to operate. One must distinguish two groups. (1) Sharply circumscribed tumors, sarcoma, endothelioma, fibroma, angioma, choletoma, dermoid tumors of the pia, solitary tubercles, gummatous growths, and, finally, cysticerci and echinococci, and (2) infiltrating tumors—glioma and carcinoma metastasis. For a favorable outcome in the first group, the location is all-important, whether extra- or intracerebral. The prognosis in tubercle, gumma, and cysticerci is unfavorable

because of the multiplicity of lesions. The prognosis in the second group is still worse, because in an infiltrating growth the border is difficult of recognition. Endothelioma, sarcoma, and neurofibroma offer the best opportunity for surgical success, and next comes cysticerci and echinococci, which are diagnosed early. When the tumor is situated in the brain stem, corpora mammillaria, pons, medulla, and third ventricle, operation is contraindicated. In all other cases it is to be recommended, though the percentage of complete recoveries is only between 3 and 4 per cent. Harvey Cushing (*Neurol. Centralbl.*, Oct. 16, 1913).

TREATMENT.—Persons suffering from tuberculous or syphilitic growths should be kept as well nourished as possible, by means of a generous and nutritious diet, and general tonics, consisting of codliver oil, iron, quinine, extract of sumbul, and arsenic, together with plenty of fresh air. In tuberculous tumors alcoholic stimulation in many instances has seemed to be beneficial in my experience. The treatment should be different in the early stages of intracranial growths from that which should be adopted after the brain has received considerable damage and the tumor attained considerable size. In the early course of the disease the patient should have the benefit of the doubt when syphilis cannot be excluded. The more acute and irritative the symptoms in cases of syphilis of the brain, the greater the demand for mercury pushed rapidly to its constitutional effect; the slower the growth, the more likely that potassium iodide will be more beneficial than mercury. In most cases, while inunctions of mercury are employed vigorously, potassium iodide should be pushed to the point of tolerance.

If with six weeks' active antisyphilitic treatment, carried to the point of tolerance, the symptoms do not begin to yield, it is probable that little will be accomplished by this method. It should be borne in mind that syphilitic subjects who are emaciated and anemic will not respond to active antisyphilitic agents until the nutrition has been improved. In the late stages of tumor of the brain prolonged and vigorous antisyphilitic agents are, to say the least, useless, if not cruel. In such cases, if improvement is not manifest within one or two weeks, vigorous measures should cease.

Suspected brain-tumor cases should not be subjected to long-continued antisyphilitic treatment, but a Wassermann test always made; if this is positive and the gumma is non-vascular, one may conclude that it will not yield to specific treatment until pressure is relieved. The patient should have the benefit of early operation. Intracranial hemorrhage should be evacuated in all cases in which the patient lives long enough to obtain skilled surgical treatment. Three to six weeks is long enough to test the utility of antisyphilitic remedies. A test for tuberculosis should always be made in cases in which there is doubt. Epilepsy rarely occurs within eighteen months of the injury and may develop years later. C. C. Rogers (*Jour. Amer. Med. Assoc.*, Sept. 30, 1911).

Headache is lessened by keeping the bowels open freely each day, the digestive organs in the best possible condition, and avoiding causes that are likely to increase the blood supply to the brain. Cold to the head and a mustard plaster to the nape of the neck often relieve an annoying headache. Sometimes local abstraction of blood from the head by means

of **leeches** to the temple or nape of the neck has been employed with benefit.

An anodyne, as **cannabis Indica**, with one of the coal-tar products, with or without **codeine**, should be employed before hypodermic injections of **morphine** are resorted to. **Mustard** to the neck and over the stomach, with cold to the head, will often relieve vomiting. Twenty to 30 grains (1.3 to 2 Gm.) of **hydrated chloral** given by the bowel in starch-water will often stop the vomiting as well as the general convulsions. **Morphine** hypodermically administered may be resorted to with confidence in the intractable cases of vomiting and general convulsions.

In cases in which the tumor is not found, if the patient is allowed to wait for some time after decompression a second operation will reveal the tumor, easily accessible. Shock can be largely avoided if the operator will work slowly and gently and employ large decompressions and exposures. *Hemorrhage* can be almost entirely controlled by the proper use of **Horsley's bone wax** and **wooden pegs** for bone hemorrhage and **Cushing's cotton compresses** and the **Haidenhein hemostatic suture** for other bleeding. Strachauer (Jour. Amer. Med. Assoc., Sept. 14, 1918).

In case the tumor is accessible to the surgeon's knife, an operation for its **removal** should not be postponed if the symptoms have failed to be decidedly modified by antisiphilitic agents, vigorously pursued for a period of from six to eight weeks. No one should think of trying to remove a carcinoma or a melanotic sarcoma from the most accessible regions of the brain, if the diagnosis of the nature of the tumor were possible or strongly probable. In some

cases of tumor of the brain, in which there is no prospect of removing the **growths**, in the hopes of relieving the severe and agonizing pain a button of bone may be removed from over the seat of pain. In 2 personal cases this procedure has lessened or relieved the pain for prolonged periods. Several other similar cases, equally successful, have been reported.

Extensive exposure of the base of the brain can safely be made. Both sides of the cerebellum can be exposed at once by forming on each side a quadrangular flap of scalp and skull, extending from the mastoid process to a point above and inside the occipital protuberance. These flaps being turned down and all bleeding arrested, the central part, not including the longitudinal sinus, is cut through at its upper and lower ends and also turned down. The bone is thick and must be partly sawed before cutting or breaking. The danger from breaking into the foramen magnum has been exaggerated. The brain is well protected here by very thick membranes. Ligation of the transverse, sigmoid, and occipital sinuses is in itself harmless. The longitudinal sinus and the tentorium must be spared. The cerebellum, being exposed, is palpated, punctured, or incised as required, and also pushed aside with spatula. If the shock is very great, it is best to wait, and to examine the brain and complete the operation later. If after the operation it is found impossible to return the cerebellum inside the dura, it is better to reduce its size by partial resection than to leave part of it outside the dura. Puncture of the ventricles is apt to lead to sudden death. The dura is loosely closed to allow escape of secretions. Prolapse after operation is not always a sign of infection, but is almost always fatal. Operation is indicated when there are signs of pressure at the base of the brain, and when the diagnosis is not certain. The first indication of

choked disc is the sign for immediate operation. Borchardt (Archiv f. klin. Chir., Bd. lxxi, 2, 1907).

The writer calls particular attention to the dangers of lumbar puncture in cases of subtentorial tumors. The possibility of an unsuspected cerebellar growth should always be kept in mind, and the puncture not made unless the dura is exposed and ready for immediate opening in case medullary symptoms supervene. Harvey Cushing (Jour. Amer. Med. Assoc., Jan. 16, 1909).

Expectant treatment in brain tumor is wrong, because it is useless. Every case of localized Jacksonian epilepsy which is not of undoubted idiopathic origin and likewise every case of progressive paralysis or anesthesia of intracranial origin (including anesthesia of the special senses), should be operated upon. The operation should be of an exploratory character, which may reveal a beginning new growth, but which, if not, will do no harm. Every case where the definite diagnosis of brain tumor has been made must be treated either by **removal of the growth** or by **decompression** for the relief of increased intracranial pressure. **Antisyphilitic treatment** should not be given for more than six weeks before operating unless there is a marked improvement. Victor Horsley (Neurol. Centralbl., Nov. 1, 1910).

Decompression should be done before the symptoms have become more than barely sufficient to enable a probable diagnosis of brain tumor to be made; one should never wait for pressure symptoms in the eye to develop. This operation has given more relief from pain and distress than almost any other in surgery. Ballance (Lancet, Sept. 13, 1913).

Although Tooth's post-operative mortality was 32 per cent., von Eiselsberg's 38 per cent., and Kuttner's 45 per cent., Cushing has reduced it to 8.4 per cent.; thus the future promises a great improvement. The most frequent form of intracranial neoplasm is the *endothelioma*

and is usually easily removed, as it arises from the meninges. The prognosis after successful removal is better than in other tumors, because it does not tend to recur unless the bone has been involved. *Gliomata*, if encapsulated or degenerated, is removable, otherwise decompression alone will probably relieve the symptoms, prolong life, and give comfort as long as a more radical procedure. Cases of *fibrous tumors*, when successfully removed, being benign, are sure of recovery. They are the common tumors of the cerebellopontine recess, arising from the sheaths of the cranial nerves, and the disastrous result is the effect on the respiratory center causing respiratory failure. *Sarcoma* is certain to recur if the brain tissue is invaded; consequently the prognosis depends on the stage at which the tumor is attacked. In *metastatic carcinoma* and *sarcoma* treatment is useless. *Cysts* may be removed or the wall partially removed and drainage established. *Tuberculomata* are usually multiple, found most frequently in the cerebellar region of children, and although often removable their disturbance is usually followed by a fatal tubercular meningitis. *Syphilomata* are usually superficial and easily removed.

The important factors are early diagnosis and early operation, and the positive indications for operation are increasing swelling of the optic disc, optic neuritis with diminution of visual acuity, unbearable headache, increasing frequency or severity of convulsions, extending paralysis, or pronounced mental changes. Baker (Albany Med. Annals, xxxvi, 230, 1915).

HYDROCEPHALUS.

This section is a revision, by the writer, of the excellent contribution by Dr. C. M. Hay to former editions.

DEFINITION.—Hydrocephalus means an accumulation of serous fluid within the cranial cavity. The condition is frequently spoken of as

dropsy of the brain, or as "water on the brain," and may occur as an acute or chronic affection. The location of the fluid varies, but is more frequently found within the cerebral ventricles than outside the brain or between its membranes.

VARIETIES.—The term "internal hydrocephalus" is applied expressly to chronic hydrocephalus usually congenital in origin, and when the word *hydrocephalus* is used without qualification it is this variety of the disease which is universally meant. Hydrocephalus may be *primary*, or *secondary* to some other disease.

Acute hydrocephalus is nearly always secondary to basilar meningitis, while chronic hydrocephalus is more frequently primary, and very often congenital; it also often develops after birth without any apparent antecedent cause. Hydrocephalus has also frequently been classified as congenital and acquired; but since many of the cases, apparently beginning after birth, really owe their origin to the same obscure causes which determine the congenital cases, it would seem better to regard the condition as *acute* or *chronic*, and as *primary* or *secondary*.

I. ACUTE HYDROCEPHALUS.

—DEFINITION.—Acute hydrocephalus means an effusion into the ventricles or within the membranes of the brain, as the result of an inflammation of the pia mater usually, either simple or tuberculous, or it may result from other intracranial or systemic organic disease.

SYMPTOMS.—The symptoms of acute hydrocephalus necessarily depend for their mode of development on the cause producing the effusion, and, as meningitis of some grade is

the most frequent cause, the signs of this disease very often precede and accompany those dependent upon the intracranial effusion. In other cases arising from gradual mechanical obstructions to the return venous circulation, the onset of symptoms indicative of ventricular dropsy may be most difficult to determine; so that, especially if other serious illness—such as summer diarrhea of infancy or one of the specific fevers—complicates the case, the diagnosis may be conjectural or even impossible. In such cases the meningeal affection sometimes runs a subacute course and gradually subsides, leaving an effusion which may, in rare cases, be reabsorbed, but which more usually tends either to remain stationary or to slowly increase in amount until the characteristic physiognomy of the hydrocephalic head is developed, and more or less permanent injury to the brain results, although such patients may survive for years in fair health.

Commonly, however, the signs of acute hydrocephalus appear during the course of one or other of the conditions to be referred to under etiology. When the primary disease is acute non-tuberculous basal meningitis, the child stricken with this disease is apt to be fretful, irritable, restless, and sleepless for from a few days to a week or two. Headache is another early symptom, and is usually combined with intolerance of a bright light, while the face is flushed and the anterior fontanelle pulsates strongly. At this early period there may also be strabismus of irregular degree. Vomiting is frequently an early symptom, and may be an extremely marked one. The tempera-

ture is that of moderate fever, but in severe cases there may be hyperpyrexia during the first two or three days or even longer. The pulse is in some cases distinctly slow and rather full, but in others much accelerated in rate and small in volume, or these conditions of the pulse may vary or alternate. The respiration is often shallow and irregular, and, after actual ventricular effusion has occurred in sufficient amount to cause compression of the brain, Cheyne-Stokes respiration is frequently noted, especially in the later stages of the disease. According to the severity of the cause producing the effusion coma develops slowly or suddenly, with twitchings and rigidity of a limb, or of all the limbs. This tremor and stiffness of the muscles may include the neck and spinal muscles, and twitching movements of the facial muscles or of the head are very common. In the rapidly fatal cases the coma deepens and the pulse and respiration progressively fail. The face is void of expression; the eyes present marked contraction of the pupils, with occasional irregular movements of the ocular muscles; convulsions may occur and be repeated many times, and the little patient dies from failure of the respiration and of the heart's action.

In some of these severe cases, inflammatory in nature, there is often a marked remission of all symptoms, including the regaining of consciousness, a lessening of the spastic condition of the muscles, and a decided improvement of the general condition. This change for the better is too often a deceptive one, and is followed by a return of the same grave symptoms noted above preceding

death. In cases of simple non-tuberculous basilar meningitis the improvement may be real and the patient slowly recover, and after some months the recovery may be a perfect one. It is more common, however, that some permanent mental or physical defect is left as the result of the effusion, and such patients are a long time in recovering from the very marked emaciation which always is present and in some cases is extreme.

The course of the disease may be extremely variable, and the duration from a few days to many months. In such cases the characteristic hydrocephalic head may develop, and the case very much resemble one of chronic hydrocephalus. This variability in this disease we must assume to be directly dependent upon the grade and extent of the primary inflammation, which in certain cases runs a subacute or almost chronic course, which may finally end in more or less perfect recovery. Even in the most favorable case, when effusion has taken place into the ventricles, it is extremely rare that this effusion wholly disappears. The clinical and post-mortem evidence is strongly in favor of the view that when effusion once occurs it is, at best, only permanently limited in the favorable cases, the brain gradually accustoming itself to the changed conditions, while the majority of the cases show a tendency toward progressive increase of the ventricular accumulation.

When tuberculous meningitis is the primary condition, the same prodromal symptoms are usually noticed as have been above noted as ushering in non-tuberculous meningitis. At times the onset is very acute, but

it is more apt to be gradual, with slowly rising temperature, which does not commonly run so high as the temperature curve of typhoid fever, nor does it often exhibit the very marked remittency usually observed in that disease. Irregularity of the pulse, some changes in the respiration rhythm, retraction of the abdomen, irregularly contracted pupils, slow and irregular lateral movements of the eyeballs and unilateral or bilateral flushing of the face, the *tache méningique*, gradually develop. A violent convulsion, followed by hemiplegia with involvement of the face, may be the next symptom, and it may or may not be preceded by twitchings of the facial and orbital muscles. In many cases amaurosis, ptosis, strabismus, or facial paralysis alone may be noticed after a convulsion. Drowsiness may be present from the beginning of the illness, but coma comes on early or late, according to the severity of the case, and the clinical picture is one of coma slowly ending in death.

Examination of 182 cases of meningitis, 94 of which were tuberculous, showed hydrocephalus present in a little over 40 per cent., while in 88 cases of non-tuberculous meningitis it was present in 50 cases, or 56 per cent. The author alludes to angioneurotic edema as a cause of internal and external hydrocephalus. Guthrie (Pract., July, 1910).

The lateral cerebral ventricles, when filled with air, can be clearly seen under the fluoroscope. By fluoroscopy **hydrocephalus** can be diagnosed accurately at all stages of its development. Several unsuspected cases of hydrocephalus have been demonstrated by the fluoroscope. The diagnosis of a false ventricular hernia (ventriculocoele) was made with certainty, because the air from the ven-

tricle could be seen to pass directly into the swelling. Dandy (Bull. Johns Hopkins Hosp., Feb., 1919).

The symptoms attending the course of other conditions producing acute hydrocephalus, and non-inflammatory in nature, naturally depend upon the nature of the obstruction to the venous circulation and the manner of its occurrence. In cases arising from enlargement of the bronchial glands the cerebral effusion may accumulate very slowly and be unsuspected until the case is far advanced, when prominence of the fontanelles, with absence of pulsation, some increase in the size of the cranium, coupled with gradually oncoming stupor, tremors, convulsive seizures, or some form of paralysis, may direct attention to the cerebral condition. The clinical course of these cases, which are fortunately of rare occurrence, is extremely variable, and the same may be said of the symptoms presented before actual dropsy of the ventricles occurs, and evidences of intracerebral pressure become manifest, so that such forms of the disease, while they may develop acutely, approach very closely and often run into chronic hydrocephalus. In all cases of acute hydrocephalus the changes in the shape and size of the skull may be very slight, and if the disease occurs after the ossification of the cranial bones such changes cannot be detected by measurements.

ETIOLOGY.—Any cause which operates by obstructing the venous circulation within the cranial cavity may cause an acute effusion of serum into the ventricles or elsewhere within the skull. Thus, intracranial tumors, enlarged bronchial glands, retropharyngeal abscess, and intracranial

hemorrhage are all causes of more or less acute hydrocephalus.

The same is true of certain diseases which cause, at times, enlargement of the bronchial glands, and thus, by pressure on the venæ in-nominatæ, obstruct the venous circulation of the brain, resulting in passive congestion and effusion of serum from the engorged blood-vessels. Acute hydrocephalus has also been frequently noted in connection with exhausting diseases, like severe cases of scarlet fever, typhoid fever, and prolonged diarrhea of children, especially that occurring in summer.

In the latter class of cases the effusion is partly the result of the actual wasting of the brain, which favors passive congestion of the organ, and is also due, in part, to the great weakness of the circulation, which is a special feature of protracted cases of infantile summer diarrhea. Syphilitic meningitis may also be accompanied by an acute effusion into the ventricles, and in all of these cases a careful study of the family history, and a very critical examination of the patient, should be made so as to discover, if possible, other evidences of the existence of syphilis.

Finally, certain writers have reported cases of so-called essential dropsy of the brain in which there could be found no anatomical lesion to explain the effusion. No case of acute effusion within the cranium should, however, be put into the last category, unless a careful and complete post-mortem fails utterly to reveal a pathological lesion, and the diagnosis of acute essential dropsy during life is certainly a wholly impossible one. Practically, acute intracranial effusion of serum is more

frequently seen as the result of tuberculous or simple leptomeningitis than from the other conditions above enumerated. (Acute hydrocephalus and tuberculous meningitis are often used as synonymous terms, but, in view of the many other conditions which occasionally give rise to the former, it would be well to discontinue such use of these terms as misleading to students.)

Occasionally intracerebral hemorrhage may result in the formation of a cystic accumulation of serum within the membranes of the brain or between them and the skull itself. Pachymeningitis may also cause a localized collection of serum. In such cases of localized cystic collections there is very apt to be marked pressure thereby of the subjacent convolutions. The amount of fluid present in any case of acute hydrocephalus is very small in comparison with the very large amount usually present in chronic hydrocephalus, and very rarely exceeds 4 or 5 ounces. When acute hydrocephalus arises from inflammatory disease of the membranes of the brain, the meningitis is commonly basilar. This is particularly true of the simple and tuberculous meningitis of children, while cases occurring in adult life frequently involve the membranes over the convexity of the brain as well. Leptomeningitis as a cause of acute ventricular effusion is most frequent before the end of the sixth year, and more often arises in subjects debilitated by previous disease, or by poor hygienic and social conditions.

Report of a case of acute internal hydrocephalus secondary to streptococcal infection of the labyrinth. An

operation on the labyrinth would probably have saved the patient's life had the true state of affairs been realized in time. S. R. Scott (*Arch. of Otol.*, April, 1908).

An internal hydrocephalus can be experimentally produced by occluding the aqueduct of Sylvius. Experiments made by the introduction of phenolsulphonephthalein into the lateral ventricles showed that the absorption of cerebrospinal fluid from the ventricles takes place almost entirely in the subarachnoid space. It passes directly into the blood, and the lymph-vessels are not concerned in its absorption.

When injected into the ventricles phenolsulphonephthalein normally appears in the urine in from ten to twelve minutes, and after two hours from 12 to 20 per cent. is excreted. After this injection into the subarachnoid space, it appears in the urine in from six to eight minutes, and from 35 to 60 per cent. is excreted in two hours. When injected into the ventricles, it appears in the lumbar spinal fluid within two or three minutes. In hydrocephalus this enables one to determine accurately the patency or obstruction of the channels of exit from the ventricles to the subarachnoid space. Fluid passes upward into the ventricles after injection of the chemical into the lumbar subarachnoid space.

With phenolsulphonephthalein two types of hydrocephalus may be readily differentiated by determining the patency or occlusion of the channels of exit from the ventricles. In the first type these channels are obstructed and hydrocephalus results because there is no absorption from the ventricles. In the second type the channels are patent and the hydrocephalus is due to diminished absorption from the subarachnoid space. W. E. Dandy and K. D. Blackfan (*Jour. Amer. Med. Assoc.*, Dec. 20, 1913).

The writers report 8 cases, all showing either complete occlusion of the aqueductus cerebri or obliteration

of the fourth ventricle by marked changes in the ependymal or subependymal tissue. Schlapp and Gere (*Amer. Jour. Pediat.*, June, 1917).

The writer found it advisable to divide the hydrocephalus of poliomyelitis into the following forms: 1. That of the onset (including the pre-paralytic and early paralytic stages). 2. That persistent after the first week of the disease and comprising three varieties: (a) a mild form commonly encountered in which there is only a slight increase in fluid and in which symptoms are practically absent; (b) a more severe form comprising various degrees, in which there are distinct signs of pressure; (c) a very severe type, more or less insidious in onset, indefinite in physical signs, and associated with evidences of progressive emaciation. Regan (*Amer. Jour. Dis. of Children*, Apr., 1918).

PATHOLOGY.—Post-mortem examination of the brain in acute hydrocephalus of inflammatory origin reveals usually a basilar leptomeningitis, which may be simple, tuberculous, infective, or syphilitic in origin, with an excess of fluid in the ventricles, causing a marked dilatation of them, while the substance of the hemispheres presents appearances due largely to the increased intracranial pressure. This intracranial tension often partly expels the blood from the vessels, especially during the last hours of life; so that at the post-mortem the brain substance may look anemic, especially over the vertex and throughout the substance of the hemispheres. In cases of simple leptomeningitis the naked eye appearances of the pia at the base of the brain will rarely present marked evidences of the intense hyperemia existing during life. The ventricles are distended with a slightly opaque or turbid serum, while the choroid

plexus is overdilated with blood, which may also be extravasated in punctiform patches in their immediate vicinity. The microscope shows extravasation of leucocytes along the lines of the blood-vessels and distending the perivascular sheaths, and also reveals minute capillary hemorrhages, pus cells, and in some cases compound granule cells, depending largely upon the duration of the disease. The cerebral substance in some cases may contain areas of softening, but the rule is to find no such lesions, and, with the exception of changes in shape from pressure, the convolutions may be normal.

When tuberculosis is present it is usually also at the base in children, but may involve large areas of the pia mater in older subjects, and in adults the vertex is not infrequently the site of the tuberculous deposit. The characteristic post-mortem appearance is the tubercle, and the location in which this is most commonly found is in the pia overlying the crura cerebri, the optic, olfactory, and the point of exit of the third nerve, and also in the membrane as it extends over the corpora quadrigemina. The pia is much thickened, is covered by a grayish-white exudate, and the tubercles show as whitish-gray bodies imbedded in the membrane. In size the tubercles vary from exceedingly minute bodies, hardly discernible macroscopically, to that of the head of a pin or even somewhat larger. The ventricles are distended with a turbid albuminous fluid, and there is thickening and softening of the ependyma. The microscope confirms the diagnosis and reveals the existence of numerous obstructions of the smaller arte-

rioles from tuberculous deposit, or an obliterating endarteritis. Giant cells may be seen in the perivascular spaces or in the cerebral substance, while the *Bacillus tuberculosis* is seen along the lines of the vessels and in and around the areas of the tuberculous deposits. In all cases the bronchial glands should also be examined, since they are frequently a most important factor in the production of the ventricular effusion.

DIAGNOSIS.—The diagnosis of acute hydrocephalus is not difficult when it occurs as the result of meningitis. In such cases the prolonged coma, the irregular movements of the muscular system, with the respiratory rhythm, are all suggestions of the increased intracranial tension due to the ventricular effusion. The subacute cases are, perhaps, the most difficult of recognition, and the condition of the brain may remain unsuspected until the graver symptoms appear. The cases arising rather abruptly from the pressure of intracranial growths or from enlarged bronchial glands also present many difficulties in the way of early diagnosis, but the appearance of grave signs of cerebral disturbance, the discovery in certain cases of other evidences of tuberculosis, or of retropharyngeal abscess causing embarrassment to the cerebral circulation, the exclusion of traumatism, the ophthalmoscopic examination, and a careful study of the history of the illness will often aid in making up an opinion. The very fatal cases which occur in large cities, especially during the course of the diarrheal diseases of infants and young children, present few difficulties in their recognition, because the brain symptoms

develop so early and progress so rapidly toward death. In these cases the tendency toward a marked, but most deceptive, remission of symptoms should be borne in mind. In all cases of acute hydrocephalus the general wasting of the body is a prominent feature. In cases of long duration the emaciation may become extreme, and contractions occur in the limbs which may be more or less permanent should recovery take place. The characteristic hydrocephalic aspect is rarely seen in acute hydrocephalus, unless the case should drift into the chronic condition, cases of which are only rarely seen. Cases arising from meningeal hemorrhage usually become chronic, the fluid being encysted between the membranes of the brain.

PROGNOSIS.—The prognosis of acute hydrocephalus is always bad. The disease ends usually in death, or in permanent mental or physical defects in the cases which escape death. Probably the syphilitic form is the most hopeful when the condition is suspected early enough to get the patient promptly under the influence of specific remedies. The cases arising from enterocolitis, or any of the acute fevers or other exhausting disease, offer little hope as to recovery, although occasionally a patient will recover. The tuberculous cases are absolutely hopeless, although Jacobi and others have testified to the recovery of two or three cases. Sub-acute basilar meningitis may cause ventricular effusion and subside, leaving the effusion, which may remain stationary in amount or even lessen in bulk so that the symptoms of its presence disappear; but usually the tendency is for it to increase, and

finally, after months or years, the clinical picture of chronic hydrocephalus is produced, should the patient have been a young child, thus admitting of the expansion of the cranium.

TREATMENT.—The treatment of acute hydrocephalus is very often that of the primary disease to which the ventricular effusion is only secondary. Sometimes, from the very rapid progress of the case toward a fatal end, treatment can be of little avail. In the majority of cases it is almost hopeless, but in all cases every effort should be made, for occasionally the recovery of one of these cases from a seemingly hopeless condition will amply repay the untiring care which they all demand.

When the initial symptoms of meningeal irritation appear, should the patient be seen at that early period, absolute **rest** in a darkened room, prompt **vesication** behind the ears with **cantharidal collodion**, in children, and regular doses of **calomel** in great amount should be instituted. If necessary, **opium** should be given to control the restlessness, preferably combined with **chloral**, and these should be continued in suitable doses so long as the twitchings and spastic muscular condition continue. **Irrigation of the bowels** should be practised where there is enterocolitis as the cause.

In all cases every part and organ of the body should be very carefully examined so as to exclude complicating conditions and establish the diagnosis. The initial treatment is of the greatest importance, for after the effusion has occurred there is less hope of doing good.

When the patient is a sthenic sub-

ject and the arterial tension high, **leeches** or **wet cups** to the **mastoid regions** may be employed. After these measures the **spinal ice-bag** should be used in the cases with high temperature; and they should be avoided in those with low temperature range, as collapse has been induced in such patients in my own experience. The **bromides** and **chloral** will usually be demanded to mitigate the tendency toward convulsions, while they both tend to lessen cerebral hyperemia. **Chloral** may be used as a **rectal injection** in cases where the stomach is non-retentive. In some cases the **warm bath** is desirable and helps to calm the muscular system.

The **diet** should be carefully regulated and stimulants should not be given unless demanded by the condition of the pulse. In the later stages signs of collapse should be watched for, and that condition anticipated, when possible, by the prompt administration of a rapidly acting stimulant, such as **ammonia**. Should the patient recover from the acute stage of the disease, **diuretics**, including the **acetate** and **iodide of potassium**, should be employed, with **tonics**, **massage**, and **electricity**, in order to increase the nutrition proportion and activity of the muscles. Although the percentage of recoveries is exceedingly small, it is large enough to warrant the utmost zeal in the treatment of these distressing cases.

In cases of epidemic cerebrospinal meningitis in which threatening hydrocephalus is detected in the second or third week of the disease, a single **lumbar puncture** is sufficient sometimes not only to relieve the symptoms, but to arrest the progress of the disease at a critical moment by

removal of the excess of toxins or bacteria from the interior of the cranial cavity. Koplik (*Amer. Jour. Med. Sci.*, April, 1907).

Puncture of brain recommended in acquired hydrocephalus. The best technique is to puncture the scalp, bore a small hole in the skull with a fine, blunt, smooth drill, and introduce a fine, hollow needle attached to a hypodermic syringe. Acute or subacute hydrocephalus in adults is frequently diagnosed as migraine, and a rapidly fatal termination may be averted by prompt puncture, as also in cases of a superficial local intracranial collection of fluid. Pollack (*Deut. med. Woch.*, May 19, 1910).

Direct puncture of the ventricles may be of service in cases of acute intraventricular effusion, and occasionally when internal hydrocephalus is progressive and bids fair to become chronic. Lumbar puncture, however, should always be tried first, even when the symptoms of pressure are associated with otitis media.

From its occasional success, **drainage of the subarachnoid space** by passing a trocar and cannula into the subcerebellar cistern, introducing a horsehair drain, sewing up the dura, and cutting off the drain close to its outer surface, is worthy of trial when, owing to obstruction, lumbar puncture fails to relieve.

Occasionally **mercurial inunction** seems to produce good results in syphilitic infants who show signs of incipient hydrocephalus. But the author does not think congenital syphilis a common cause of hydrocephalus. In early stages **leeching** the occiput is not an irrational procedure. The author has known recovery just once to take place in well-marked postbasal meningitis after powerful counterirritation with **tartar emetic ointment**. Such methods are useless unless applied early. L. G. Guthrie (*Pract.*, July, 1910).

Ventricle drainage by **puncture of the corpus callosum** in acute obstructive hydrocephalus due to cerebrospinal meningitis is recommended by

the writers. In case of epidemic cerebrospinal meningitis which, after running a relatively normal course, rather suddenly developed signs and symptoms of obstructive hydrocephalus, it was decided to puncture the corpus callosum. This was done some ten days after admission to the hospital, the patient being in a raving delirium. About 25 c.c. of very slightly turbid, blood-stained fluid was obtained, whereas four hours previously, 40 c.c. of cloudy fluid had been withdrawn by lumbar puncture. Ventricular block was proved by the way in which the fluid gushed from the cannula. The immediate improvement was almost miraculous. Stetten and Roberts (Jour. Amer. Med. Assoc., Jan. 25, 1919).

II. CHRONIC HYDROCEPHALUS.—DEFINITION.—Chronic hydrocephalus means a progressive accumulation of serum within the ventricles of the brain, or in rare cases external to the brain and between its membranes, or between them and the skull itself; or in all of these situations. It is characterized by enlargement of the head, an almost pathognomonic facies, and by a progressive tendency toward death; often from gradual failure of the vital powers, or from intercurrent disease, or rarely from rupture of the head.

VARIETIES.—The term *internal* hydrocephalus is used to denote the cases in which the effusion is ventricular, while *external* hydrocephalus is used to denote the cases in which the effusion is external to the brain. The former class of cases is by far the more numerous, and is meant when the word hydrocephalus is used alone. The disease may also be *primary* or *secondary*. Many of the cases are congenital, but in the majority of instances it is first noticed some weeks after birth.

SYMPTOMS.—The symptoms of chronic internal hydrocephalus and the external variety of the same disease are similar and differ only in degree. External hydrocephalus is extremely rare, and is secondary, in the vast majority of the cases reported, to meningeal hemorrhage and to pachymeningitis. It is also found in cerebral atrophy, probably as a compensating lesion, and also has been found in cases of congenital cerebral malformations. The amount of fluid found is very small in comparison with that found in internal hydrocephalus, but some cases have been reported in which the head was decidedly enlarged and the sutures separated.

Internal hydrocephalus, which is the ordinary variety met with in practice, presents as its chief symptom an enlargement of the head. In some cases this enlargement is very great, as in a case reported by Steiner which exhibited a cranium $32\frac{3}{4}$ inches in circumference at the eighth month. The normal circumference of the head at one year is given by Holt as from 18 to 19 inches. The increase in size of the head is usually in all directions, and the sutures in marked cases are widely separated, while the cranial bones are expanded and thinned out until sometimes they have a parchment-like sensation to the touch. The fontanelles are very large and bulging; the veins of the scalp are engorged; fluctuation of the head is quite common, and it may also be translucent to light. The scalp is stretched and thin and exhibits very little hair.

On the other hand, internal hydrocephalus may exist with no perceptible enlargement of the head and

with perfect, and even premature, ossification of the cranial bones. Primary cases of internal hydrocephalus are most often congenital, but in most cases the condition is only recognized after some weeks subsequent to birth; but in other cases the condition develops rapidly *in utero*, and puncture of the head may be necessary to effect delivery. In the largest class of cases nothing is noticed until several weeks have elapsed after birth, when the abnormal size of the cranium attracts attention. The child is also noticed to have difficulty to support or move the head, or is incapable of supporting it at all. Soon drowsiness and apathy are apparent in the infant, and it sinks into a condition of hebetude with all the senses less acute than normal. There is apt, at this time, to be either undue flaccidity or stiffness of the extremities. The latter condition is more common and the thumbs are adducted with the fingers tightly closed. The pupils are usually contracted, but at times irregular or dilated. There is marked general emaciation. Convulsions may occur and be repeated, and slow rolling of the eyeballs laterally or more or less strabismus may be features of the case.

The rapidity of the enlargement differs very much in different cases, and the clinical history depends largely upon this fact. In cases in which the increase of fluid is very slow the brain seems to accommodate itself to the pressure, and the symptoms of intracerebral pressure may be very few or almost entirely lacking until the case is far advanced. When chronic hydrocephalus is secondary, and arises after ossification

of the cranial bones is firmly established, the symptoms of increased cerebral tension are earlier and more markedly seen, although the amount of fluid in the ventricles is relatively very small in comparison to the primary cases. A well-developed case of internal hydrocephalus presents quite a striking and characteristic appearance. The face is small and overshadowed by the enlarged cranium; the forehead is prominent and bulging; the eyes are directed down and formed so that the white of the eye is always more or less uncovered by the upper lids; the child is often restless, and there is frequently twitching of the extremities; a short, sharp cry is often given, and, taken in connection with the emaciated body, the picture presented is almost pathognomonic of the disease. The head is often rather flat behind, with bulging sides and greatly rounded frontal regions.

ETIOLOGY.—Chronic hydrocephalus arises often, especially the congenital cases, without any demonstrable lesion of the brain. In many cases it is due to meningitis, or to other organic disease of the brain, such as tumor. Some authorities attribute a large proportion of the cases to syphilis, which certainly does appear often in the family histories.

Other authors ascribe the congenital defect to rickets, but this connection is not by any means clearly proved, for much confusion has arisen from the fact that, clinically, rickets and hydrocephalus have frequently been confounded, but they are sometimes associated. Primary hydrocephalus has also been causatively referred to tuberculosis, but there is lack of positive evidence. The influence of heredity is probably an im-

portant factor; often two or more children in the same family have been affected.

Extreme overwork and worry in the mother constitute, I believe, an important factor in determining the occurrence of primary hydrocephalus. It must be admitted, however, that we are still in the dark regarding the essential causative factor of primary hydrocephalus. In some cases of secondary hydrocephalus the cause can be clearly traced to an antecedent mild attack of basilar meningitis, or to a basal tumor, or to some mechanical cause producing venous stasis in the vessels supplying the ventricles.

PATHOLOGY.—The lesions found *post mortem* are caused by the enormous dilatation of the ventricular cavities in which the effusion usually accumulates. Thus in very marked cases all the walls of the ventricles are extremely thin, the septum lucidum is obliterated, and sometimes the brain substance forms a mere envelope for a large central cavity formed by the gradual expansion of the ventricles. In more extreme cases nearly all of the brain substance may have disappeared through the effect of the great pressure, and the brain resembles a cystic tumor, with only the basal ganglion and cerebellum and portions of the temporo-sphenoidal remaining, as in a case of Peterson's, referred to by Holt. The fluid found in cases of chronic hydrocephalus is slightly alkaline, translucent, specific gravity about 1005, and contains a trace of albumin and sometimes sugar. It also contains traces of alkaline chlorides and phosphates. The fluid in cases arising from meningitis is usually more turbid and contains a larger percentage

of albumin. The quantity of fluid varies from a few ounces, in secondary cases, to 6 pints or more in primary cases.

The brain substance is anemic; often there is no line of demarcation between the gray and white matter, and the effects of pressure are evident in bad cases, which show, under the microscope, marked degeneration of the nerve elements. In lesser grades of effusion the microscopic changes may be scarcely noticeable. The ependyma may be normal in appearance, but is often found thickened, infiltrated with leucocytes, and granular to the naked eye. In some cases it has undergone degenerative changes. In most cases some changes are found in the ependyma, and it is probable that these lesions are often directly responsible for the effusion itself, and that they result from an antecedent attack of ependymitis, simple or specific in character, and often occurring in fetal life.

Report of a case of internal hydrocephalus induced by a probably congenital, almost total occlusion of the aqueduct of Sylvius. The subject was an elderly woman who was supposed to have been born hydrocephalic; but in spite of this and of an epilepsy that had lasted for years, had lived to the advanced age of 62, and retained her faculties fairly well developed. The aqueduct, while almost entirely occluded, was well lined throughout by a layer of ependymal cells, which would not have been the case had its occlusion been due to neuroglia proliferation, as in a previous case reported. W. G. Spiller (Jour. Amer. Med. Assoc., April 13, 1907).

The bones of the cranium are more or less widely separated, sometimes to the extent of 3 inches. More rarely premature ossification has occurred, and in these cases the head is

not enlarged. The cranial bones are remarkably thinned, and may be almost as thin as paper. Spina bifida is quite frequently associated with hydrocephalus, and, less frequently, some form of meningocele or encephalocele complicates the case.

PROGNOSIS.—Complete recovery is practically unknown. In the most favorable cases the enlargement of the head spontaneously ceases after some years, and the patient may live for many years, but with no diminution in the size of the cranium. Mental defects are common in such cases. The majority of cases progress more or less rapidly to a fatal end. The rapid cases die within the first year, and it is very uncommon for a case of marked infantile hydrocephalus to live over the sixth year of life. Death usually results from marasmus, intercurrent disease, or from convulsions ending in coma from which the patient cannot be roused. Very rarely rupture of the head is a cause of death.

DIAGNOSIS.—The diagnosis is usually an easy one. Chronic hydrocephalus must be distinguished from rickets and hypertrophy of the brain. No error is liable to occur in the very marked cases, but when the effusion is of moderate amount the diagnosis may demand careful examination. From hypertrophy of the brain hydrocephalus is separated by its more rapid development, the greater enlargement of the head, the fluctuation which is often present, the universal character of the expansion of the cranium, which is more marked at the vertex in hypertrophy of the brain, and by the almost pathognomonic facies of hydrocephalus, including the oblique direction of the

eyes, with failure of the upper lid to completely cover the eyeball. To the touch hydrocephalus is softer and more compressible than hypertrophy.

From rickets chronic hydrocephalus is distinguished by the rounded head, which in rickets is square or angular and often marked by nodules; also by palpation and the other signs of the hydrocephalic head above noted. In rickets, also, there will usually be other evidences of the disease in other parts of the body.

Cases of chronic external hydrocephalus may present more difficulties in diagnosis, but they are of very rare occurrence, and careful examination will usually separate them from the cases under consideration.

TREATMENT.—The treatment of chronic hydrocephalus by internal remedies only rarely results in any benefit. Probably the best diuretic and alterative in these cases is the **iodide of potassium**, which should be given a trial in cases where it is not especially contraindicated.

Surgically, **compression** of the **skull** by adhesive plaster applied in strips has been tried, and cases of marked improvement have been reported as resulting from this treatment. The treatment much in vogue is a combination of **pressure** by means of **adhesive strips** covering in the entire vault and sides of the cranium, with occasional **aspiration** of moderate amounts of fluid, followed by the re-application of the adhesive plaster. The effects of the pressure must be carefully watched and the strips loosened or removed should dangerous symptoms appear. If syphilis is suspected **mercurial inunctions** to the head should be practised.

Other modes of treatment are: **in-**

cision with drainage, puncture by the trocar, blisters, and lumbar puncture. When any operative interference is considered, the preference of the writer is for repeated aspiration with strapping of the head.

Krause found a light silver tube introduced into the ventricle useful for continuous drainage.

The effects of single or repeated spinal or ventricular puncture are much improved when supplemented with large doses of potassium iodide internally. Heile (Deut. med. Woch., Aug. 20, 1908).

That certain types of hydrocephalus (choroidorrhea) may be of toxic origin is deemed probable by the writer, since brain, plexus, or pituitary extracts, and also muscarine, have a stimulating, thyroid a depressing, effect upon the choroid secretion. Von Bramann's **ventriculostomy** is recommended both in hydrocephalus of obstructive type and in essential choroidorrhea in infancy, before cerebral destruction has occurred. C. M. Remsen (Interstate Med. Jour., xxii, 89, 1916).

Four types of hydrocephalus are recognized by the writer: (1) *Hydrocephalus obstructivus*. This, the old "internal" variety, is due to blocking of 1 of the outlets for cerebrospinal fluid through a congenital defect or by inflammation. It must be differentiated from the other varieties, as the treatment differs. (2) *Hydrocephalus non-absorptus*. Absorption of fluid is defective as proved by the phenolsulphonaphthalein test. (3) *Hydrocephalus hypersecretivus*. Probably due to disease of the choroid plexus. (4) *Hydrocephalus occultus*. Occurs usually in children, is characterized by excess of fluid, without enlargement of the skull, and symptomatically resembles a brain tumor. Such a case was operated upon and relieved.

In determining the variety, phenolsulphonaphthalein is injected into the lumbar subarachnoid space, and the

urine tested. Next day the drug is injected into the lateral ventricle, and its excretion into the spinal canal tested by lumbar puncture. With these tests one localizes an obstruction if there is one.

In the obstruction type, **puncture of the corpus callosum** is advocated; in the non-absorptive type, **drainage** into the pleural cavity. In a case due to hypersecretion, **thyroid feeding** proved very successful. C. H. Frazier (Amer. Jour. of Dis. of Child., Feb., 1916).

In operating for hydrocephalus, the writer inserts 6 linen strands into the ventricles in the internal type, and merely into the subarachnoid and subdural spaces in the external type of hydrocephalus, and brings their ends through the temporal muscle and fascia beneath the scalp in a stellate manner. Of 41 cases, 13 could not survive the sudden loss of cerebrospinal fluid. Later this difficulty was overcome by elevating the head. In the other 28, results were very encouraging, all but 6 showing progressive improvement. Sharpe (Amer. Jour. Med. Sci., Apr., 1917).

Every effort should be used to increase the nutrition of the patient by **codliver oil, tonics, massage, and careful feeding**, in the hope that the effusion may become self-limited and permit of life's being continued with more or less impairment of the mental and physical health.

ERNEST LAPLACE,
Philadelphia.

HEART AND PERICARDIUM, DISEASES OF THE. (see also **ENDOCARDIUM AND VALVES, DISEASES OF**, Vol. IV; **ANGINA PECTORIS**, Vol. I, and the sections that follow the present one).

GENERAL DIAGNOSIS.—Functional Efficiency Tests.—During the war several efficiency tests were employed to considerable advantage. T. E. Satterthwaite (Med. Rec., Feb. 21, 1920) reviewed those which

might prove of use in general practice. These consist of: The *trigeminal irritation test*, the inhalation of strong smelling salts that slow the normal heart but accelerate the neurotic heart. The *oculocardiac test*, elicited by pressure on one or both eyeballs. By this method the normal rate is slowed 4 to 10 beats per minute. Any increased degree of retardation suggests trouble with the cardioneural mechanism. The *atropine test*, in which from 1/25 to 1/50 grain increases the normal beat from 30 to 40 per minute, while in hearts with myocardial degeneration the increase may be only 20 beats or even less.

Other tests depend upon the reaction of the heart muscle to either active or passive exertion. Of these, the *Selig test* has been very frequently used. The pulse and systolic blood pressure are taken before and after the subject climbs a flight of 20 steps. Normally there is an increase of 20 beats per minute and a rise of blood pressure of 8 mm. Hg. If the myocardium is insufficient, the pulse rate increases 30 or more beats, while the blood pressure rises more slowly, or falls. The length of time taken for the recovery to the normal systolic pressure may be regarded as the index of cardiac efficiency. The *hopping test* consists in having the patient hop 20 paces on one foot. It is a modification of the Selig test, but not so valuable as some others, inasmuch as the work performed cannot be computed accurately.

Graüpfner's test is a better method, as it consists in having the patient perform a definite amount of work with the ergometer, and depends on a comparison of the behaviors of pulse rate and arterial pressure. In the normal heart under exercise the systolic pressure rises after the acceleration of the rate, and after rest is maintained, longer than in the inefficient heart where the pressure rise is both delayed and diminished. The *stair climbing test* is another practical and useful method, in which the amount of work is estimated in foot-pounds, the latter being computed by multiplying the number of pounds the individual weighs by the number of feet ascended. Thus an energy-index is provided.

The *Herz test* introduces simple flexion and extension of the arms; in persons with weak hearts the rate increases 5 to 20 beats a minute.

Katzenstein's test consists in compressing both femoral arteries. If the arterial pressure rises some 15 mm. Hg. and the pulse rate does not rise, or even slows a little, the heart is held to be vigorous. If the pressure falls and the pulse rises in rate the heart is insufficient. Satterthwaite has used *Schapiro's test* about 10 years. The pulse is taken first in the recumbent and then in the sitting position. In health there is an increase of frequency, when the individual has assumed the sitting posture (after lying down), of from 3 to 10 beats per minute. In the weak heart there is an absence of change or a diminution of the frequency in changing from the recumbent to the sitting position. This method is applicable for ordinary civilian practice.

Secher (Ugeskrift for Laeger, Dec. 4, 1919) describes a number of tests which are simple enough for office or house practice.

In *Schrumpff's test*, if the heart is normal, the pulse should return to its former beat in 4 minutes after slight exercise, such as bending the knees 10 times.

Katzenstein's test is the difference in pulse and blood pressure before and 2 minutes after digital compression of the femoral artery for 2 or 2½ minutes. A rise in blood pressure and slower pulse-rate indicates normal condition. An abnormally high rise in blood pressure is found in arteriosclerosis and cardiac hypertrophy. No rise in blood pressure indicates weakness of the heart; if the pulse is not modified, the weakness is slight, but if the pulse grows faster the heart must be regarded as decidedly insufficient. A drop in blood pressure with accelerated pulse indicates severe insufficiency; it is proportional to the degree of each. This test can be applied to the reclining patient. The writer's experience with it in 50 cases demonstrated its approximate reliability. In some cases it excluded organic heart disease, and the course later confirmed its findings. The *Rehfsch test* is by auscultation before and after bending the knees 10 times; *Bock's differential stethoscope* eliminates the personal equation in estimating the findings.

Injection of 1 or 2 mg. of *physostigmine salicylate* retards the heart beat always unless myocardium and innervation are abnormal. Negative response shows the rhythm no longer obeys the supracardiac nervous system. Mougeot (Bull. Soc. Méd. des Hôp. Apr. 15, 1921).

IRREGULARITY OF THE HEART BEAT.

Within the last decade there has been so great an advance in our understanding of the cause and clinical significance of this subject that it must be given fuller consideration than it has received in the past.

The normal wave of cardiac contraction starts in a small mass of tissue, called the *sinoauricular node*, which lies at the mouth of the superior vena cava. The wave spreads from this point over both auricles and is transmitted by a narrow muscular tract, the *auriculo-ventricular bundle*, to each ventricle. This band takes its origin near the sinoauricular node and proceeds downward to the membranous septum of the ventricle, where it divides into two main branches. These branches then subdivide repeatedly to be distributed to the ventricular musculature through the complex network of Purkinje fibers.

Sinus Irregularity.—Sinus irregularity is produced by interference with the rhythmic impulses as they arise in the sinoauricular node. The irregularity affects the whole heart and consists of a gradual waxing and waning of rate. The great majority of irregularities which occur before the age of 10 are of this variety, and most of them bear a definite relation to respiration. The radial beats are all of the same height. They occur so frequently in persons who show no other sign of disease that they cannot be regarded as anything more than exaggerations of normal phenomena. It is, nevertheless,

important to recognize them so that they may not be confused with other types of irregularity.

Irregularity of the heart in children during convalescence from febrile illness is not uncommon. It may be due to arrhythmic contraction of the heart's chambers or disturbance in the conduction of impulses from auricle to ventricle. These disorders suggest disease of the myocardium and are of serious prognostic import. In the majority of cases, however, the irregularity is solely due to variations in length of the diastolic phases of the cardiac cycle, while in all respects the heart's mechanism is normal. Sinus arrhythmia is a form of irregularity devoid of any pathological significance whatever. Its frequent occurrence after acute illness in children is not generally known to practitioners, the irregularity being confused with those of pathological origin. Its recognition is important, otherwise the patient is needlessly kept in bed and subjected to unnecessary treatment. While, as a rule, the diagnosis of sinus irregularity is readily made on clinical examination, exceptionally it is only established from records of the heart's movements and respiration. Windle (Quarterly Jour. of Med., April, 1912).

Heart Block.—This is caused by interference with the transmission of the impulse from auricle to ventricle. The interference manifests itself in various ways:—

1. There is a mere prolongation of the interval which separates the beginning of auricular and of ventricular systole.

2. The ventricle fails to respond to occasional auricular systoles ("dropped beats"), anticipated by a progressive lengthening of the preceding auriculo-ventricular interval.

3. Every second, third, or fourth beat is dropped.

4. There is complete dissociation between auricle and ventricle,—each beats in its own rhythm. The independent ventricular rhythm is about 30 to the minute.

Case in a man 32 years old, in whom the syncopal seizures were pronouncedly epileptiform. The pulse was only paroxysmally very slow, being nearly of a normal rate during the intervals. The ventricular systole coincided with the radial pulse. The seizures did not come on while the man reclined, but he said that his head swam when he sat or stood up. Each seizure was preceded by a sensation of malaise and was followed by torpor and difficult enunciation. A. M. Rubalcava (*Revista de Med. y Cir.*, April 10, 1912).

Heart block occurs most commonly in rheumatic affections of the heart, in degenerative diseases of the myocardium, and, finally, as a result of digitalis administration.

The writer describes 4 types of transient heart-block: (1) partial auriculoventricular block of myocardial origin, occurring during an exacerbation of acute rheumatic carditis; (2) complete auriculoventricular block, brought on by digitalis, and temporarily reducible by atropine to a 2:1 rhythm; (3) defective conductivity in the right branch of His' bundle in the aged with arteriosclerosis, chronic myocarditis and anginoid symptoms; (4) periods of prolongation of the P-R interval (to more than 0.3 second) in a healthy subject. Krumbhaar (*Arch. of Internal Med.*, May, 1917).

Heart block may be temporary or persistent. When persistent it is a sign of myocardial damage, not necessarily limited to the bundle, but probably diffuse. When occurring as a temporary sign in the course of febrile diseases, it may be the only evidence that the myocardium has been damaged.

Disturbances of the function or condition in the heart muscles after infectious diseases probably occur oftener than is generally recognized. They seem more frequent in rheumatic cases. The disturbance may be either complete or partial. Complete block is due in most instances to an organic lesion of the conduction fibers, and may, apparently, be due in part to nervous influences. Partial block is usually transient, and is probably due to the action of the vagus nerve in a poisoned myocardium. Peabody (*Archives of Intern. Med.*, March, 1910).

Case of diphtheria, with full heart block, in which the auriculoventricular bundle and node were found to be involved in an acute inflammatory process. Similar lesions were present in the auriculoventricular bundle in a case of malignant endocarditis in which conductivity was defective. In 3 cases of acute endocarditis, with nodal rhythm, the auriculoventricular node was acutely inflamed, the bundle in one being only and but slightly affected. J. Cowan, G. B. Fleming, and A. M. Kennedy (*Lancet*, Feb. 3, 1912).

Instance of temporary partial heart block as a sequel to acute pneumonia. The pulse was irregular for a period of three weeks, commencing to be so a week after the crisis. The irregularity was usually more marked in the evening, and appeared to give the patient no discomfort. Examination of the heart did not at any time reveal any physical signs of disease. The type of irregularity was fairly constant. The pauses never at any time appeared longer than would be accounted for by one missed beat, and, as a rule, one long beat would follow three, four, five, or six shorter and regular ones. This state of matters continued till about four weeks after the crisis, when the pulse again became perfectly regular in rate and rhythm. Dykes (*Lancet*, Oct. 12, 1912).

Case in which ventricular extrasystoles appeared usually after exer-

cise. When the dissociation was complete, the period of extrasystoles—2:1—was followed by slowing of the ventricular rhythm, the auricular rhythm remaining unaffected. Conversely, when 1:1 rhythm was present, the rhythm of the whole heart became slow and irregular after a bigeminal period. The pauses after the premature contractions were often considerably shorter than the intervals between the rhythmic ventricular beats owing to a momentarily depressed conduction. Naish (Quarterly Jour. of Med., Jan., 1913).

The writer observed *acute heart-block* in a young man who complained of headache for 2 weeks, then had a sore throat and pains in the feet, but no fever. He grew suddenly dizzy and fell. L. Laursen (Ugeskrift for Laeger, Jan. 27, 1916).

Recent experimental research has demonstrated that there is certainly some connection between the cardiac fibers of the sympathetic and the conduction of the impulse, but that the latter is almost entirely, but not quite, independent of these fibers. This justifies the administration of **adrenalin** owing to its marked action on the sympathetic nerve. Heitz (Arch. des Mal. du Coeur, Feb., 1916).

The writers found experimentally that where incomplete dissociation of the auricular and the ventricular beats exists, injection of **adrenalin** causes almost entire disappearance of the heart-block and a pronounced increase in the heart rate. It is indicated, therefore, in cerebral anemia during attacks of heart-block. Danielopolu and Danulescu (Presse méd., Feb. 17, 1916).

The writers observed heart-block in a girl of 2½ years. Symptoms were noticed while the child had fever. The auricular beat was 107 a minute, the ventricular beat 42.8. Digitalis retarded slightly the auricle rhythm, but had no action on the disturbance in conduction. Frank and Polak (Neder. Tijdsch. v. Geneesk., June 10, 1916).

Experiments on dogs and clinical experience confirm that adrenalin does not break up heart-block when there is total dissociation. It may even bring on partial heart-block in hearts with apparently normal conduction of the impulse and accelerate the rhythm of the auricles and ventricles, but it acts on them separately, and they retain their independent beat in the total block cases. Hardoy and Houssay (Revista de la Asoc. Med. Argentina, Oct., 1917).

When types 3 and 4 of heart block occur in connection with epileptoid convulsions, and slow pulse, we have the symptom-complex known as **Adams-Stokes disease**.

Single dropped beats are recognized by finding a pulse, otherwise regular, which is occasionally interrupted by a pause of unusual length. During the pause there is neither movement nor sound at the apex.

"Two to one heart block" is to be suspected in any patient in whom the ventricle beats regularly at a rate which lies between 40 and 50 to the minute. The condition is usually unstable, so that sudden changes are common and these occur as halving or doubling of the previous rate.

In complete heart block the pulse is strikingly slow—35 or under—and quite regular. Frequently one may hear faint sounds during the long pauses, due to the systoles of the auricles, which are beating at a more rapid rate. Further evidence is gained by watching the pulsations of the jugular veins in the neck. It is noticed that the jugular vein pulsates between beats of the carotid artery, and that from time to time, independent of respiration, the jugular pulse is very large.

Case of an old hemiplegic who was known to have complete heart-block for ten months. He also had marked

Cheyne-Stokes respiration. The electrocardiograms showed frequent changes in the electric complexes of the ventricular beat. The nodal artery was later found sclerotic. Oppenheimer and Williams (Med. Rec., May 31, 1913).

While any grade of heart-block may persist without developing the Adams-Stokes syndrome throughout the patient's life, the seizures constituting the syndrome, a sudden marked slowing of the usual pulse accompanied by attacks of unconsciousness with or without convulsions, occur most frequently in subjects suffering from permanent progressive complete heart block. They also occur in incomplete dissociation with a permanent idio-ventricular rhythm well established. The immediate cause of the seizures may usually be traced to some unusual physical activity. The cause of the seizures, whether confined to unconsciousness or accompanied by fits, is sudden cerebral anemia, due to the abrupt slowing of the ventricular rate. Mild attacks are marked by vertigo, faintness, pallor, loss of consciousness and absence of ventricular beat. Severe seizures occur where the ventricular standstill lasts 15 minutes or more. Here venous engorgement causes pallor, cyanosis, unconsciousness, twitching of the face or an arm, and occasionally the fits become generalized. In these attacks the patients do not pass urine or bite the tongue. In the mild cases, breathing may be normal; in the severe attacks stertorous and apneic. The only suggestion of an aura is that at times the patient is aware of the slowing of the ventricular rate, with varying pauses between beats, from a normal rate to one of 30 per minute. A single period of ventricular standstill of from 3 to 7 seconds usually causes unconsciousness; 15 seconds or more causes convulsions in addition. The outlook depends upon the extent of the myocardial degeneration and the frequency and severity of the fits. Sudden death in a first attack is rare. The majority

of these patients die of progressive heart failure. This fact should not make one underestimate the gravity of these seizures. Even a mild attack of unconsciousness calls for a period of absolute **rest in bed**. A single injection of **atropine sulphate**, $\frac{1}{50}$ grain (0.0013 Gm.), may be tried. To prolong the effect, $\frac{1}{100}$ grain (0.00065 Gm.) may be given by mouth to physiological effect. Heart stimulants such as digitalis and strophanthin are mostly contraindicated. J. E. Talley (Trans. Amer. Electro-Therap. Assoc.; Med. Rec., Nov. 27, 1920).

The *general symptomatology* of heart block, besides the slowness of the heart beat in high-grade cases may include fullness of the pulse and high systolic pressure (170 to 200 mm. Hg) when there is enough normal or healthy cardiac tissue to sustain a persistent heart block. *Marked* pulse slowing with epileptoid convulsions brings the disorder present within the field of the Adams-Stokes syndrome. When the pulse falls to 20 beats a minute or below, sometimes down to 8, unconsciousness occurs.

The earlier symptoms of the higher grades of heart block may include brief attacks of vertigo, fainting, temporary unconsciousness, pallor and pulselessness. In the more severe case cyanosis occurs, owing to damming back of the venous blood, with stertorous breathing, facial twitching—the onset in some cases of a general epileptoid attack, though the tongue is not bitten. Status epilepticus may then supervene and death follow.

These attacks may occur without warning, though ventricular slowing or a change in the heart's action usually appear—danger signals which the medical man should heed.

In the *treatment* of this condition digitalis should be avoided. **Bella-**

donna or its alkaloid, **atropine**, has been recommended, along with treatment of any general disorder that may be present. When epilepsy was present **thyroid extract** and **nitroglycerine** were proved efficacious.

With Lewis, we should recognize that heart block and the Adams-Stokes syndrome are not synonymous terms—as taught in some textbooks—the main destructive feature of the latter being the epileptoid attacks. In simple *heart block*, then, we should **avoid digitalis** and place our confidence in **atropine**, which is often effective in counteracting the block by paralyzing the vagal terminals. Where syphilis is suspected as a cause **mercury** or the **iodides** should be tried, the **salicylates** in rheumatic cases, the **iodides** when arteriosclerosis prevails, etc. Briefly, the cause should be carefully sought and removed where possible. Overexertion and violent emotions are very dangerous in such cases. In the *Adams-Stokes syndrome* the myocardium seems, on the other hand, to demand additional tone. This is best met, in addition to treatment of the original cause, by means of **strychnine**. In some cases, particularly when there is dilatation, **digitalis** in moderate doses, or a good fluidextract of **cactus grandiflorus**, in 30-drop doses, are to be preferred. **Sodium citrate** and **sodium iodide** have been found beneficial by some observers. **Hypodermoclysis** and **saline solution intravenously**—but without adrenalin, which would aggravate the block—suggest themselves as valuable aids in the treatment of threatening cases, owing to the diminished viscosity and the enhanced osmotic properties of the blood it would insure. Editorial (N. Y. Med. Jour., Nov. 15, 1913).

The writer has observed several cases of extrasystoles (premature beats), 1 of auricular flutter and 1 of auricular fibrillation, due to tobacco poisoning. In a man of 28 years who had been smoking uninterruptedly

since the age of 15, there was sinoauricular block—standstill of the entire heart—1 beat in every 3 to 5 beats being completely missing. With **cessation of smoking** and **bromides**, the sinoauricular block disappeared in 3 days, but the extrasystoles persisted, then disappeared under **digitalis**, **theobromine**, and the **Karrel diet**. S. Neuhof (Arch. of Internal Med., May, 1916).

Premature Contractions (incorrectly called “extrasystoles”).—These are contractions of the auricle or ventricle occurring before the anticipated time, as the result of stimuli arising in abnormal places. The work accomplished by premature beats is small and may or may not be sufficient to raise the aortic valve. When premature contraction interrupts the rhythm of a regularly beating ventricle, the abnormal contraction is accompanied by an early apex beat and a small early arterial pulse, if the valves are opened; or, merely, by an early apex beat and an intermission in the arterial pulse, if the valves remain closed. In either case the condition is distinguished from heart block by the occurrence of the premature apex beat in the condition under discussion.

In heart block there is no sound or movement at the apex during the long pause. When each third ventricular contraction is premature, the arterial beats occur in triplets if the systole has been strong enough to open the aortic valve, or in pairs if the aortic valves are not opened. When premature beats alternate with normal ones, the arterial beats are paired if the aortic valves are open; or the arterial pulse is halved if the valves are not opened. When the premature beat is of ventricular origin, it, plus the preceding contraction, equals two normal cycles in time. When the premature beat is auricular in origin, this period is less than two cycles.

Premature contractions are an indication of disturbance of cardiac nutrition, but this view should not be given undue prominence, for a number of persons who show no other sign of disease are temporarily affected by this form of irregularity. In such instances it would be wrong to suppose that the cardiac disturbance is of a serious nature. Other persons may show premature contractions from infancy to good old age without ever manifesting any other signs of cardiac disease. It may accordingly be said that premature contractions are relatively of slight importance as compared with other forms of irregularity.

Extrasystolic arrhythmia may simulate heart block by the fact (1) that the peripheral pulse may be very slow; (2) that the jugular veins may be distended and pulsate markedly in the intervals between the radial pulses; (3) that a muffled third muscular sound may be heard on auscultation over the heart which does not correspond to a peripheral pulse; (4) that there are no distinctive symptoms of true heart block. Norris (Univer. of Penna. Med. Bull., Jan., 1910).

As to *treatment*, no drugs are known which will influence the occurrence of this form of irregularity. Digitalis is useless as a direct remedy.

Auricular Fibrillation.—When the auricle passes into fibrillation the chamber maintains the position of diastole and systole is never accomplished. The chamber as a whole is motionless, but, nevertheless, close observation will reveal that the muscle is undergoing incessant, rapid, minute twitchings. The normal stimulus to contraction is absent, but a number of stimuli are being produced in small areas of the auricle and are being showered upon the ventricle. "When the heart is beating rapidly at

100 to 160 per minute, the grade of disorder is maximal. The radial artery supplies indifferent news of the ventricular rate; many pulsations fail to reach it. The pulse is a medley of beats of many sizes and intimate mingling of changing pauses; now the beats are almost uniform in strength and spacing; now feeble pulsations chase along rapidly; now the pulse is lost; now it returns with increased vigor. Feel the pulse and the mechanism is apparent; the more the disorder, the more certain the evidence. When the ventricle beats irregularly, surpassing 120 per minute, the irregularity is almost always of this nature. When an irregular ventricular action accompanies signs and symptoms of serious heart-failure, it is probably the result of auricular fibrillation." (Thomas Lewis.)

Electrocardiograms taken from patients exhibiting this irregularity show a number of irregular waves apart from the ventricular curve, and more clearly defined in diastole. Such waves are found in no other disorder of the heart action. They disappear when irregularity vanishes, are not evident upon the cardiogram, and are identical with the curves yielded by fibrillation of the auricle. Furthermore, synchronous tracings show that the waves in the experimental cardiogram correspond to the fibrillary movements of the auricle. Lewis (Brit. Med. Jour., ii, 1909).

Auricular fibrillation can be recognized without resort to polygraphic tracings. If one relies on a continuous and complete irregularity, not on an occasional one, a visible systolic pulsation in the veins of the neck, and signs of venous engorgement with the absence of a pre-systolic murmur, there will be few cases in which the diagnosis will prove erroneous. Herapath (Bristol Medico-Chi. Jour., June, 1911).

In commonplace language, fibrillation of the auricle practically

amounts to a trembling palsy of part of the heart, but a palsy that casts an influence over the healthy part of the heart. The healthy part of the heart is perfectly able and willing to contract regularly, but at a very slow rate. The paralyzed part of the heart is constantly lashing the healthy part of the heart into contractions, but when the heart has contracted once it will refuse to contract again until after it has had a rest, and then as soon as it is able it contracts to the next impulse. If we would cut the bundle of His in a case of fibrillation of the auricle, the heart would act regularly, but very slowly.

In clinical medicine this affection when understood gives brilliant results in response to treatment. It is always to be suspected when the pulse is very irregular. L. F. Bishop (*Med. Record*, May 6, 1911).

While the exact cause of auricular fibrillation is unknown, it usually comes on in a heart in which there has been for a considerable period disease of the valves or myocardial change from inflammation or degeneration. Sometimes it arises suddenly where there has been no previous sign or symptom of heart disease. Possibly in some of these cases it occurs in hearts which were previously perfectly healthy. If this is true its essential cause must lie outside the heart and not in any anatomical or pathological change in the heart itself. A. M. Gossage and J. A. B. Hicks (*Quarterly Jour. of Med.*, July, 1913).

This type of irregularity is seen most frequently in mitral stenosis. Lewis states that it occurs in from 60 to 70 per cent. of all cases of cardiac failure admitted to a general hospital. The myocardium generally shows a marked degree of inflammatory and degenerative change.

Rheumatism or chorea preceded auricular fibrillation in 56.6 per cent. of the cases examined by the writer.

The most frequent lesion to which it gave rise was mitral stenosis (43.6 per cent. of cases with rheumatic history). Non-rheumatic cases presented auricular fibrillation in 43.4 per cent., the most frequent cardiac lesion being cardio- or arterio- sclerosis, 57.1 per cent. The age incidence of mitral-valve disease, with or without preceding rheumatism, was 38.2 years; the age incidence of cardiosclerosis was 53.9 years in rheumatic cases, 56.9 years in non-rheumatic. Females were more frequently subject to valvular disease than males in the proportion of 16 to 10; males were more subject to arterio- or cardio- sclerosis, 15 to 8. C. E. Lea (*Quarterly Jour. of Med.*, July, 1911).

The writers, after a study of the subject, conclude as follows: In auricular fibrillation palpation of the radial pulse is a misleading guide to the determination of the condition of the circulation. The pulse deficit is a simple and useful means of following the progress of cases of auricular fibrillation, and of confirming observations on the value of various therapeutic measures, including the activity of various preparations of different drugs. The relative deficit is of value in the diagnosis of suspected cases of fibrillation. The ordinary method of estimating blood-pressure is misleading in cases of auricular fibrillation; it may with advantage be replaced by estimating the average systolic blood-pressure, which gives an approximate measure of the real systolic pressure. The administration of digitalis elevates blood-pressure in cases of auricular fibrillation. W. B. James and T. S. Hart (*Amer. Jour. Med. Sci.*, Jan., 1914).

It is important to recognize this clinical form of irregularity, not only because it tells us that the myocardium is seriously involved in the particular case, but also because it is an "absolute indication for the administration of digitalis whenever the heart

rate exceeds 100 while the patient is at rest." Auricular fibrillation is the condition in which digitalis shows its most brilliant effects.

No disease of the heart responds so satisfactorily to **digitalis** and its allies as auricular fibrillation. But not all cases of fibrillation react thus brilliantly to digitalis; the slow, irregular heart in which fibrillation is accompanied by impaired conduction is comparatively little improved. The condition which responds to digitalis most readily and satisfactorily is the rapid, irregular heart of old rheumatic disease, in which fibrillation is present along with good conductivity through the bundle of His and a readily responding ventricle. Here digitalis reduces the pulse rate rapidly from 120 to 150 to 60 to 70, and as the pulse falls the whole of the symptoms improve. If the drug be pushed the pulse continues to fall and may reach 40 to 50. Beyond this, digitalis generally induces other symptoms from the gastrointestinal tract so that its dose has to be reduced. Cushny (Amer. Jour. Med. Sci., June, 1911).

In this condition the auricles of the heart beat with extreme rapidity, usually at the rate of about 300 per minute; 16 cases are reported. When the condition develops it usually persists for months or years, although it may occur in shorter paroxysms. As a rule, the ventricular rate is one-half of the auricular, but any grade of block may be present, so that the ventricular rate may vary from 30 to 300. The ventricular rate is controlled by the degrees of block in the bundle of His. This may be increased by digitalis and its allies, which thus slow the ventricles. Auricular flutter is closely related, on the one hand, with similar tachycardias of lesser rate, and, on the other, with auricular fibrillation; and it may pass either into the one or the other. **Digitalis** may stop the condition by diverting it into fibrillation, which condition may later be con-

verted spontaneously into the normal rhythm. Lewis (Heart, vol. iv, p. 171, 1912).

The treatment of auricular fibrillation resolves itself into an observance of the general rules of treatment of heart-failure and the use of **digitalis**, **strophanthus**, or **squills**. The patient must, of course, be confined to bed. If cyanosis and right-heart dilatation are great, the abstraction of 6 ounces of blood by **venesection** or the use of **leeches** will often be of great help; apparently by relieving some of the distention of the heart, it paves the way for the action of the cardiac remedies. It is impossible to exaggerate the importance of **rest**, and both physical and mental calm should be secured. In this connection the writer strongly advocates the earlier and bolder use of **morphine** in heart-failure. The dangers of this drug in these cases are not as great as have been supposed, and the benefit from its use is often great. A contraindication to the use of morphine is the presence of a pleural effusion reaching to the sixth rib posteriorly, or the occurrence of nausea and vomiting. In the absence of these complications, the restlessness of heart-failure, especially if accompanied by pain, is a direct indication for the use of the drug. Zundel (Clin. Jour., June 4, 1913).

Case in which, when auricular fibrillation appeared, a fall in the ventricular rate from 120 to 80 occurred. **Strophanthin**, administered intravenously some weeks later, exerted a strikingly beneficial effect on the circulation and subjective symptoms. The post-mortem examination showed a lesion of the sinoauricular node, but it could not be definitely asserted that a relation existed between the lesion and the clinical irregularity. Cohn and Heard (Arch. of Intern. Med., June, 1913).

No form of cardiac disorder is more amenable to proper **digitalis** medication than auricular fibrillation. Its effects or those of its allied drugs

are oftentimes no less than marvelous, patients in immediate peril of death being relieved as if by magic. Gordinier (Albany Med. Annals, July, 1916).

Pulsus Alternans.—The rhythm is regular, but every other beat is smaller than the preceding one. It is seen especially in arteriosclerotic affections of the heart and in chronic renal disease, and should be regarded as a sign of a fast-failing muscle. It is accordingly a most valuable sign, having the same significance as angina pectoris, for example. Unfortunately, it can scarcely ever be recognized without the aid of instrumental methods. However, the Dudgeon sphygmograph is amply sufficient for this purpose. After a little practice a few moments will suffice to make a satisfactory tracing by means of which the condition is easily recognized.

The writers had observed, in taking the systolic blood-pressure in certain severe cases of nephritis, that when this pressure was attained, the finger placed over the radial artery did not feel a sudden cessation of the pulsations, but for a certain period perceived alternate beats. From this they have developed more sensitive methods of detecting pulse alternation than those hitherto in use, digital palpation and the sphygmograph. The first requires the use of the ordinary mercury sphygmanometer. When the pressure in the cuff is still 10 to 20 mm. below the systolic level, the finger palpating the radial perceives, in a case of alternating pulse, first an increased difference between the strong and weak beats, then a sudden cessation of the weaker beats. By substituting a sphygmograph for the finger, tracings illustrating these changes can be obtained. With a dial sphygmanometer, similar modifications are seen in observing the movements of the needle. Where no instrument is

at hand, the brachial artery should be compressed against the humerus, just above the bend of the elbow, with the index and middle fingers of one hand. By gradually increasing the pressure, the other hand, palpating the radial, will at a given period feel only alternate beats. Although it is somewhat difficult to maintain an even pressure over the brachial, very slight degrees of alternation, which cannot be detected by mere radial palpation and which are hardly noticeable in ordinary sphygmographic tracings, can thus be demonstrated. The importance of early recognition of the *pulsus alternans* lies in that the latter is the only form of arrhythmia which gives direct information concerning the contractile power of the myocardium, without regard to irritability and conductivity. L. Gallavardin and L. Gravier (N. Y. Med. Jour., from Lyon méd., Dec. 29, 1912).

The writer has had 45 patients under observation, showing the *pulsus alternans* in the following conditions, stated in order of frequency: 1. Arterial and myocardial disease. 2. Chronic heart disease due to rheumatism. 3. Pneumonia. 4. Paroxysmal tachycardia. 5. Acute rheumatic carditis. It is the writer's experience that the presence of the *pulsus alternans* in a case of myocardial and arterial disease always adds to the gravity of the prognosis. It signifies disease of the heart progressing inevitably to a fatal end, and this is its meaning when present, as it not seldom is for a time, in patients whose clinical condition does not suggest serious unsoundness of the heart. In the case of 33 patients with myocardial and arterial disease under his observation, the diagnosis of the *pulsus alternans* was established in each case by polygraph tracings, and records were taken systematically during the time the patients were under notice. Five of these patients died within a year; 2 lived eighteen months, and 2 twenty-four months, after the *pulsus alter-*

nans first showed itself. Windle (Quarterly Jour. of Med., July, 1913).

The writer has used *digitalis* with benefit in over 100 cases of this form of arrhythmia. This is contrary to the current teaching that *digitalis* is contraindicated in this condition as likely to make it worse. *Digitalis* in full doses not only removes the alternation, but relieves the dropsy and dyspnea. Windle (Quart. Jour. of Med., July, 1917).

Having discovered *pulsus alternans*, the indication for *treatment* is simple. Curtailment of mental or physical exertion, prolongation of the hours of rest and the avoidance of emotions and anxiety are imperative. Anesthetics jeopardize life.

MYOCARDITIS.

DEFINITION.—Myocarditis is characterized by a change in the heart muscle, which may be either inflammatory or degenerative, resulting in a diminished integrity of the tissue.

The term "myocarditis" should strictly be applied only to those conditions in which there is real inflammation of the heart muscle, and so would scarcely ever be used except when speaking of acute cases. The chronic variety is almost always degenerative, resulting from insufficient nutrition of the muscle.

VARIETIES.—Myocarditis may either be acute or chronic, local or diffuse. The acute and the chronic forms are so different in their origin and course that they seem more like two separate diseases than modifications of a single disease. In both, however, the important result from a clinical standpoint is the deterioration of the muscular fiber and consequent impairment of function.

SYMPTOMS.—**I. Acute Myocarditis.**—The onset of acute myocarditis

may be abrupt, but it is more often insidious, merging itself with the symptoms of the primary disease, for it is always the result of some previous morbid condition. Its beginning may be attended by an increase of fever, or even a true rigor; the patient may complain of discomfort or pain in the cardiac region. The pulse becomes rapid and feeble; and if an unfavorable course is taken, it subsequently grows weak and intermittent, and, toward a fatal termination, noticeably infrequent.

Myocarditis is the cause of sudden death in convalescents from scarlet fever much more frequently than is generally recognized. A case is cited in which a girl of 15, apparently recovered from a mild attack of scarlet fever, died suddenly while at stool. In another case an infant of 18 months had been in the diphtheria ward for a month on suspicion of diphtheria, but with negative bacteriological findings. Then a scarlatinal eruption developed and faded and the child was apparently doing well, when it suddenly died. Necropsy revealed acute myocarditis, notwithstanding the total absence of myocarditic symptoms during the illness. Weill and Mouriquand (Presse méd., Aug. 5, 1911).

Dilatation ensues, as shown by a displacement of the apex beat toward the left and an increase in the area of cardiac dullness. The first sound at the apex becomes feeble and indistinct; there may be heard at the same place a gallop rhythm. At the base of the heart the pulmonic second sound may be accentuated and reduplicated. The general condition of the patient shows the stress of his illness; he lies prostrate in bed with pulmonary congestion, dyspnea, increasing cyanosis, and perhaps coma or delirium.

The development of heart block during the course of an acute rheumatic illness is an evidence of myocardial involvement, not necessarily limited to the auriculoventricular bundle, but almost certainly spreading to a greater or lesser extent beyond it. The sensory tract, when implicated, is responsible for signs which, relative to the extent of the lesion, are far more conspicuous than those yielded by implication of the general mass of the ventricular muscle. T. Lewis (Brit. Med. Jour., March 8, 1913).

The imperfect circulation may occasion a scanty and albuminous urine; enlargement of the liver, perhaps accompanied with catarrhal jaundice, and catarrh of the stomach, with vomiting. The condition thus sketched is not invariably present; milder attacks serve merely to aggravate the general weakness of the patient, and to delay, but scarcely to compromise, his recovery.

II. Chronic Myocarditis.—The clinical progress of chronic myocarditis varies greatly in rapidity. Some cases may prove fatal so early as to make the term "chronic" seem inappropriate. Others progress slowly for a time, and terminate abruptly in unexpected death. Still others—and these are the majority—develop gradually and bring the patient to his end by a slow process, which may extend over many years. Cases are also found, *post mortem*, which have not given rise to important symptoms even up to the time of death, to which event the change in the myocardium has not at all contributed.

A case of diffuse, purulent, ventriculoseptal myocarditis with Adams-Stokes syndrome in a man aged 67. He had had syphilis thirty-seven years before and had been at one time a hard drinker, though more

moderate of late years. His health had been good until seven months before his admission to the hospital, when he began to have vertigo and syncope, with epileptiform attacks coming on suddenly and very frequently. Three months after the onset of the attacks a cough developed, with slight expectoration, and dyspnea on slight exertion became annoying. He was found dead in his bed six days after his reception. At the autopsy microscopic examination showed the bundle of His involved in an acute primary purulent infiltration; this accounts for the attacks and symptoms witnessed. H. G. Beck and W. R. Stokes (Jour. Amer. Med. Assoc., Sept. 24, 1910).

When the process is gradual the symptoms are mainly those of diminished cardiac efficiency. There may be pain or uneasiness in the precordium or attacks of true angina pectoris. Dyspnea appears at first after some unusual muscular effort; it gradually becomes more marked, and may at last render the patient unable to utter more than a few words at a time without pausing for breath. Dyspnea may also come on in a paroxysmal way, resembling attacks of asthma, and often described by the term "cardiac asthma." In early stages the pulse may be more frequent than in health, and of good strength or even somewhat more than normal tension. As the heart becomes more affected the pulse becomes weak, irregular, intermittent, and in some cases infrequent.

The most important symptoms of myocardial degeneration are irritability of temper, melancholia, loss of memory, precordial pain, palpitation, dyspnea, diminished physical and mental endurance, pulse alterations and slight edema of the ankles. These are attended by more or less change in the physical signs, which,

however, are not distinctive until late in the disease. Often the process goes on without symptoms until an attack of angina pectoris or fainting appears, but in most cases there are some antecedent symptoms within two or three years. E. F. Ingals (Jour. Amer. Med. Assoc., April 27, 1912).

In this chronic form, also, as well as in acute myocarditis, the heart is apt to be enlarged, and the apex beat may be displaced downward as well as outward. It is the rule to find dilatation of one or both ventricles; the left is more often the one affected. In some cases there is also more or less hypertrophy of the muscle walls. The influence of muscular exertion upon the action of the heart is an important criterion of its integrity, and in suspected cases this test should never be omitted. The climbing of a single flight of stairs, for instance, may amply demonstrate the precarious condition of the circulation. The dilatation of the left ventricle often occasions relative insufficiency of the mitral valve, and a consequent murmur of mitral regurgitation heard at the apex, and transmitted to the left axilla, with accentuation of the second pulmonic sound at the base of the heart. The heart's impulse may be extensive, but feeble in character, striking against the chest a quick, weak blow. Sometimes, however, the apparently vigorous efforts of the heart are striking even when the radial pulse is feeble and ill sustained.

The brain being imperfectly supplied with blood, we may have such cerebral symptoms as vertigo, loss of memory, wakefulness, headache, delirium, and coma. The lungs may suffer from bronchial catarrh, edema, or hydrothorax. The Cheyne-Stokes

mode of respiration may be observed, especially near death. The digestive and renal changes may be the same as with the acute form of the disease. It is not only true that the urine is scanty under such conditions, but it is also deficient in the proportion of waste products which it contains, the retention of which poisonous material in the system has been regarded as one cause of the asthmatic seizures already mentioned. The patient is also subject to attacks of syncope. These may be slowly recovered from, and even fatal. Again, death may occur during an attack of angina. In other cases death comes more gradually with the well-known symptoms of cardiac dilatation.

DIAGNOSIS.—Absolute certainty with regard to the existence or non-existence of myocarditis in any particular patient is often difficult, if not impossible, and certainly any candid clinician who has had opportunities of comparing his ante-mortem diagnoses with post-mortem appearances will acknowledge the liability to error here. One is greatly aided in deciding for or against myocardial involvement by the evidence obtained by means of modern cardiographic methods. Fatty degeneration of the heart may give rise to many of the symptoms above enumerated, and it is often associated with arteriosclerosis; but it is rather less likely to cause angina pectoris. Moreover, the heart sounds and the apex beat are apt to be less distinct in fatty degeneration than in some instances of the disease under consideration. Absolute certainty in differentiating these two diseases is at present impossible.

Valvular disease with failing compensation may produce a very similar

symptom-complex. We have already seen that myocarditis may occasion mitral insufficiency; it may also be associated with aortic regurgitation, both conditions being associated with atheroma of the aorta. Furthermore, chronic myocarditis may exceptionally occasion a contraction of the tissues at the base of the heart in such a manner as to cause stenosis of the aorta or pulmonary artery. The right ventricle may dilate as well as the left, causing tricuspid regurgitation. Conversely, chronic valvular disease with failing compensation may be accompanied by chronic myocarditis. The main factors which would enable us to distinguish to some extent between the valvular and myocardial disease are: first, etiology; and second, the history of the individual case. If a patient has no cardiac murmur whatever, and yet presents other well-marked signs of cardiac disease, we are more justified in regarding the case as myocardial than as valvular, and yet severe mitral stenosis may exist without any audible murmur. The most characteristic symptoms of chronic myocarditis are: persistent slowness of the pulse, especially if associated with arrhythmia, angina pectoris, and sclerosis of the peripheral arteries.

ETIOLOGY.—I. Acute myocarditis is always secondary to some infection: either through a perforating trauma or by means of the blood or by continuity of tissue. It complicates typhoid fever, scarlet fever, diphtheria, variola, cerebrospinal meningitis, pneumonia, influenza, malaria, rheumatism, and, in rare instances, tonsillitis.

The writer undertook the blood examination of rheumatism, but found his cultures from the blood-stream

to be sterile. He then injected the serum of such blood intravenously in dogs and rabbits; to the naked eye this was followed by no result, but microscopically there resulted areas of cellular infiltration of general distribution, but most evident in the papillary muscle, and chiefly perivascular. The cells are sometimes of one kind, sometimes of various sorts, lymphocytes, leucocytes, and plasma-poor cells with large nuclei; subsequently fibrotic processes appear. Four cases out of 5 showed these areas, which were never found in control animals. Blood from persons sick of nephritis, polyneuritis, and tuberculosis showed lymphocytic areas with slight muscular degeneration; but the author has not regarded them as specific, as are the areas under consideration. They bear great likeness to the so-called "rheumatic nodules" observed in the heart-muscle of persons dead of rheumatic fever. Bindo de Vecchi (*Arch. de méd. expér.*, vol. xxiv, p. 352, 1913).

It may be caused by sepsis, as in malignant endocarditis, puerperal fever, osteomyelitis, erysipelas, and gonorrhea. In some instances the specific germs of these various infections are carried to the heart with the blood; this has been demonstrated in the case of typhoid fever, septic diseases, and gonorrhea. There is also clinical reason to believe that myocarditis may be occasioned by the toxins of infectious diseases, and, indeed, this has been demonstrated experimentally in the lower animals.

In pericarditis and endocarditis there is a superficial inflammation of the adjacent cardiac muscle.

II. Chronic myocarditis sometimes ensues upon the acute process; it may develop as a result of venous stasis in advanced valvular disease, or in prolonged obstruction of the pulmonary circuit by chronic emphysema, fibroid phthisis, and pulmonary atelectasis. By

far the most important cause, however, is arteriosclerosis, with which, therefore, its etiology coincides. Important influences favoring the development of both arteriosclerosis and chronic myocarditis are: heredity, the male sex, advanced life—over forty, chronic alcoholism, syphilis, gout, lead poisoning, chronic nephritis, severe muscular labor, and excessive mental exertion or anxiety. So far as the volition of the individual is concerned, the etiology might, perhaps, be summed up in one word "excess." The process is favored by cachectic conditions: for example, carcinoma, tuberculosis, inanition. The chronic process is a result of malnutrition of the myocardium. This may depend partially upon the poor quality of the blood-supply, but would seem to be very much more influenced by the amount of blood which flows through the cardiac vessels. Venous stasis diminishes the rapidity of flow in normal channels; arteriosclerosis diminishes the lumen of the arteries. An atheromatous plate may cover the origin of a coronary artery, or the artery may be narrowed by an hypertrophy and contraction of its coats, and thrombosis or embolism may completely obstruct it.

Perhaps the most common and most important of all the causes are the metabolic disturbances in the muscle-fibers produced by the constant presence in the blood of toxins or the presence for even a comparatively short time of some very virulent poison. Ritter (*Jour. Amer. Med. Assoc.*, March 6, 1909).

The writer reports 11 cases of myocardial incompetence due to chronic cholecystitis. A healthy heart muscle may endure such a disturbing influence or may recover quickly from its derangement of function. A myocardium already the seat of structural disease, on the

contrary, is seriously affected by conditions of strain or by illness which otherwise would prove harmless. Therefore, since chronic infection of the gall-bladder manifests itself chiefly in persons at or past middle age, when presumably the heart muscle is no longer so able to resist attacks, there are furnished the conditions capable of producing the symptom-complex reported in these cases. The explanation of the baneful effects on the heart of some cases of gall-bladder disease and not of others is hypothetical, and accordingly several theories may be advanced: (1) the circulation in the blood of bacteria or their toxins; (2) the depressing influence of bile constituents on the myocardium; (3) disturbance of the splanchnic circulation and, secondarily, of the systemic circulation and heart; (4) a reflex inhibition through irritation of the vagus. It is quite possible that a different explanation is applicable to different cases and, moreover, that there must be a predisposing cause residing in the heart muscle, that is, chronic myocarditis, in consequence of which the heart is unfavorably affected by influences which a healthy myocardium would be able to resist. R. H. Babcock (*Jour. Amer. Med. Assoc.*, June 12, 1909).

Recent writers (Déhio, Radasewsky) describe a diffuse microscopic myofibrosis affecting chiefly the auricles and associated with the most varied cardiac lesions, which is referred to excessive tension of the heart walls. It is found with various valvular lesions, emphysema, and interstitial nephritis, and may develop in persons as young as 15 to 30 years of age.

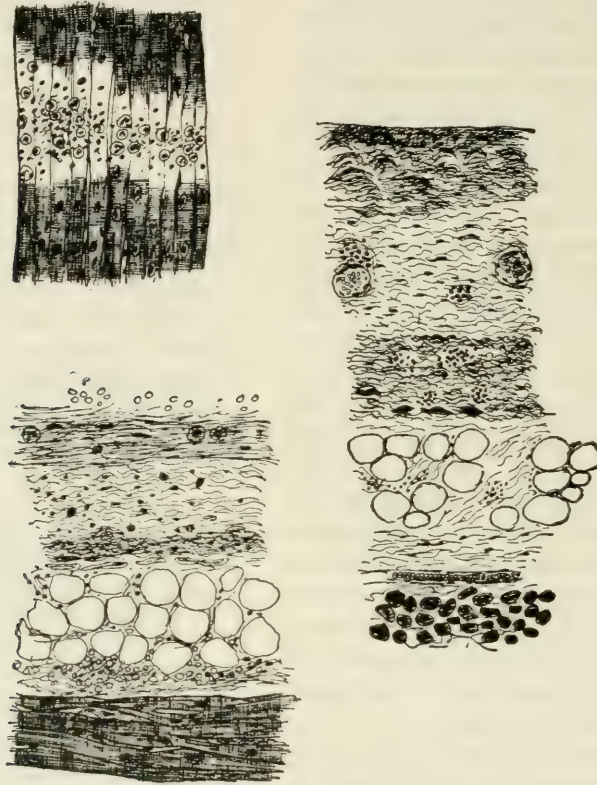
Case in which symptoms of chronic myocarditis followed a traumatism to a man, 29 years old, who had previously been healthy, had never suffered from rheumatism, nor had had any trouble that could be ascribed to heart disease. The traumatism was

a kick against the knee which threw him so forcibly upon his back as to render him unconscious. Osten (Münch. med. Woch., Apr. 12, 1910).

In a series of cardiac cases seen during a period of 3 years in general hospital wards there were 367 without organic valve lesion—that is,

relatively uncommon below the age of 40. A. Christian (Jour. Amer. Med. Assoc., June 22, 1918).

PATHOLOGY.—I. Acute Myocarditis.—There may be a diffuse purulent process affecting primarily the interstitial tissue and secondarily the



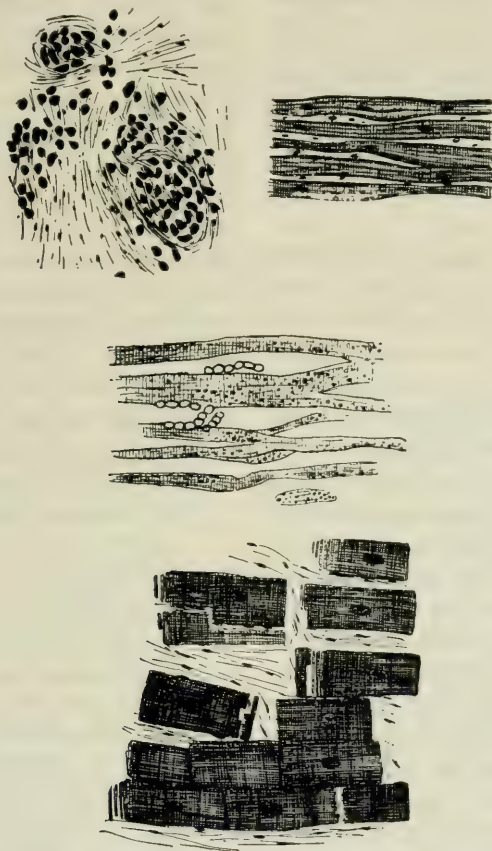
True inflammation of the myocardium. (W. H. Porter.)
(Post-Graduate.)

chronic myocarditis—and 359 with organic valve lesion. In a series of 107 consecutive autopsies on patients with cardiac disease who were over 50 years of age, mitral endocarditis was found in only 2, confirming the rarity of organic mitral lesions in persons past middle life. Chronic myocarditis was found more frequently in males than in females, in the proportion of 240 males to 167 females and it was most frequent in the decade between 52 and 60 and

muscles. This sometimes occurs in scarlet fever and also in other instances from unknown causes. Localized suppurations or abscesses are far more common and are due to infective emboli in the septic diseases mentioned before under ETIOLOGY. Broken-down muscle-fiber and bacteria are mixed with the pus in these abscesses. They may be as minute as the head of a pin or as large as a filbert. One was found to contain

an ounce of pus. Later results of these abscesses are various. They may invade the pericardial sac and cause purulent pericarditis. If located in the septum they may open an abnormal communication between the heart's cavities.

Some observers are inclined to doubt the possibility of a true inflammation of the myocardium. There is, however, a sufficient number of well-authenticated cases of myocarditis on record, supported by necropsy findings to fully establish



Varying degrees of pigmentary changes. (W. H. Porter.)
(Post-Graduate.)

Rupturing through the base of the heart, they may cause an abscess in the mediastinum. If situated in the walls of the ventricles, they may discharge into one of the cavities of the heart and give rise to diffuse sepsis; or they may cause rupture of the ventricular wall, with sudden death from hemorrhage; or finally they may, in very rare and fortunate instances, be absorbed or capsulated.

the existence of such a lesion. See illustration on p. 244. On the other hand, there is no question but that in many instances the conditions recorded as inflammatory have been entirely devoid of any and all the changes essential to an inflammatory process. They are simply varying degrees of degenerative changes, brought about by disturbances in the metabolism of the myocardium. Mixing two or more absolutely different processes and lesions together

under the common term, inflammation, has been the chief cause of the endless confusion in connection with the use of the term "myocarditis."

If the changes, which, strictly speaking, are inflammatory, last for any length of time, there will be produced, as a necessary sequence to the associated disturbance in the nutrition of the myocardium, varying degrees of degenerative changes, such as mucoid, pigmentary, granular, fatty, and fragmentary transformations. See illustration on p. 245. W. H. Porter (Post-Graduate, May, 1907).

These purulent processes are almost invariably fatal. The ordinary infectious fevers, such as typhoid, pneumonia, and the like, above enumerated, do not occasion so grave disturbances. Between the muscular fibers are found leucocytes and proliferating nuclei, which may go on to form new connective tissue. The blood-vessels are enlarged and engorged. The muscular fibers are more or less affected. The nuclei may disappear, the striæ become indistinct, and the fibers granular or even fatty. In limited areas there may be found associated with this parenchymatous degeneration, especially in the case of prolonged fevers, a hyaline change, the muscular fibers becoming swollen, homogeneous, and translucent, and their striæ very faint or entirely absent.

The degree of the parenchymatous myocarditis just described varies greatly in different cases. Its severity does not run parallel with the height of the fever, but bears a close relation to the virulence of the specific intoxication.

The present prevailing conception of this acute infectious myocarditis is that the injury to the muscular fiber is the primary condition, and that the interstitial changes are a reactive inflammation,

secondary to the disorganization of the muscle.

II. Chronic myocarditis is generally regarded as merely a degenerative, and not an inflammatory, process. Other names for it are chronic interstitial myocarditis; fibroid myocarditis, and fibroid infiltration, or cirrhosis, of the myocardium. Its most frequent causes are lesions of the coronary arteries. It may also be associated with chronic pericarditis and chronic endocarditis. Occasionally it is seen where none of these diseases exists. It may be comparatively diffuse or circumscribed, the parts most commonly affected being the left ventricle and the septum between the ventricles, and in these portions of the heart it is more marked near the apex than near the base.

So much attention has been focused on the pericardium and endocardium in rheumatic subjects that the myocardium has been more or less overlooked. Personal studies have shown that dilatation of both ventricles is constant and often of considerable degree. The auriculoventricular orifices share in the stretching. Hypertrophy of both ventricles is usually present, and in many instances without any obvious mechanical cause. The changes in the heart are mainly microscopic, and consist of slight, fatty changes in the cells, but the important point is the formation of nodules in the stroma.

The histological changes appear to be the result of an inflammatory reaction, and are characteristic of rheumatic as opposed to other forms of carditis; similar changes are seen in rheumatic endocarditis, pericarditis, and subcutaneous rheumatic nodes. The toxemia accounts, no doubt, for the greater part of the fatty changes in the cells, as well as the dilatation and hypertrophy. Carey Coombs (*Quarterly Jour. of Med.*, vol. ii, p. 26, 1908).

It consists in a growth of new connective tissue between the muscular fibers, which latter atrophy and degenerate. The process may be one of very slow development, corresponding with slow diminution in the lumen of the corresponding artery, or it may begin abruptly as the result of embolism, or more frequently thrombosis, of the coronary artery or one of its branches. The anterior or left coronary artery is the one most apt to be diseased; hence the frequency of the change in the left ventricle.

When the lumen of the artery is suddenly closed, the portion of the heart dependent upon that artery for nutrition becomes necrotic.

The muscular fiber breaks down into granular detritus, and the connective tissue undergoes a retrograde metamorphosis; so that the affected portion becomes yellowish white or gray and of soft consistency. It may be also of a dark-red color from the blood and present the appearances of an hemorrhagic infarction. This softened area of myomalacia may occasion rupture of the heart or acute inflammation, or it may be gradually absorbed and superseded by new connective tissue, which finally contracts, forming a scar.

The portion of the heart affected by interstitial degeneration is thinner than normal. The remainder of the heart may become hypertrophied to a certain extent; finally, it is almost certain, if life is prolonged, to become dilated. The fibroid spot may be so situated as to make no great difference in the contour of the heart wall, but, if situated toward the apex of the heart, it may yield to the tension of the contained blood and give rise to a cardiac aneurism. Such an aneurism may be found after death in cases where it has not

greatly affected the health of the patient. Or, again, it may finally rupture and cause sudden death, or it may become so large as fatally to impede the activity of the heart. Furthermore, on the internal surfaces of cardiac aneurisms thrombi are apt to form, and these may give rise to embolic processes. In some cases the fibroid parts of the heart exhibit a calcareous deposit.

When chronic myocarditis is the result of pericarditis or endocarditis, the process is a diffuse one and superficial, involving the fibers adjacent to the inflamed membrane. As already stated, valvular disease of chronic pulmonary obstruction, in the terminal results of cardiac dilatation and venous stasis, may give rise to fibroid changes in the heart muscle. These are more or less diffuse. They may demand careful microscopic examination in order to be detected, and their symptoms merge with and aggravate the effects of the original disorder.

Fatty degeneration of the myocardium may be associated with the presence of numerous spirochetes of syphilis, without any reaction on the part of the interstitial tissues. This would probably indicate a very acute or mild (latent) infection, and is found very frequently in congenital syphilis. Again, a calcification or fibroid change may follow the parenchymatous change without the occurrence of a definite interstitial inflammatory reaction. The spirochetes are few in number, or have entirely disappeared in such areas, according to the stage of the secondary process. Warthin (*Jour. Amer. Med. Assoc.*, Feb. 10, 1912).

PROGNOSIS.—I. Acute Myocarditis.—Diffuse suppuration or abscess formation is almost invariably fatal. The parenchymatous changes associated with infectious diseases aggravate the

patient's malady and lessen his resistant powers, but they are of comparatively favorable prognosis. Undoubtedly very many more of such patients recover than die. As in many other conditions, recognition of the danger is of great advantage to the patient. The avoidance of undue exertion and the careful nursing and feeding of the sufferer contribute much to his safety.

II. Chronic Fibroid Myocarditis.—

The prognosis varies with the abruptness and the extent of the degeneration. Slow diminution of the lumen of a large branch of the coronary artery, even down to practical occlusion, may sometimes be endured by the heart without very marked embarrassment, whereas the thrombotic closure of the same vessel may result in immediate death; but between these two extreme instances are many degrees of disturbance. Minute patches of fibroid degeneration hardly affect the heart's activity. More diffuse changes, however, impair its functional ability. In particular, it proves unequal to any unusual demand upon it. Then, finally, even under ordinary conditions it can no longer maintain the circulation, and the signs of cardiac failure gradually develop.

The prognosis in an early stage of the process may be said also to depend in considerable degree upon the intelligence of the patient, his self-control, and his ability to fulfill the demands of treatment. The hard-drinking long-shoreman beginning to break down under arteriosclerosis is sure to fail more rapidly than the fortunate individual who can withdraw from business activity and enjoy years of easy travel in Europe.

There are cases in which, without organic change, the heart is unable to functionate normally. While the

symptoms may be the same, the underlying pathogenesis may be widely different and is susceptible to analysis into the classes enumerated in this paper. No correct prognosis can be made or rational treatment instituted until these pathogenic factors have been recognized and assigned their proper value. Power (Calif. State Jour. of Med., July, 1911).

TREATMENT.—We have no efficient treatment for the acute suppurative form of myocarditis. Prophylaxis is desirable so far as it can be attained. For example, the writer would advocate in specific urethritis the administration of **phenyl salicylate** or some other antiseptic excreted with the urine. Sajous recommends **hypodermoclysis** or at least rectal injections of **saline solution** as prophylactics in the various infections.

Whatever tends to cut short the original disease will lessen the chance of this secondary cardiac disturbance. It may possibly be that **antistreptococcic serum**, if injected, might aid in prophylaxis. Further than this, the treatment can be merely supportive and stimulating. Where there is precordial distress, **hot applications** may be made or a **sinapism** applied. Some authors recommend **ice-bags**, but in view of the extreme feebleness of the patient it is a question whether cold might not prove depressing. Absolute rest in bed should be insisted upon, all violent motions or exertions being carefully avoided.

Drugs, especially **digitalis** and other heart tonics, are of doubtful value and may even prove harmful. **Camphor** or **caffeine** may be used if vasomotor failure appears.

The acute parenchymatous form of myocarditis, associated with the infect-

ive fevers, does not demand essentially different treatment from that suitable for the original disease. What has already been said about external applications will apply in these cases also, and, if signs of cardiac embarrassment develop, the **diet** must be restricted and simplified and stimulants and heart tonics exhibited. The patient should not be allowed to make any unnecessary efforts so long as the pulse remains irregular and intermittent. Death has more than once occurred as the result of sitting up suddenly in bed after prolonged fever.

Chronic myocarditis should be treated in the first place by removing or mitigating its causes, so far as possible. The patient's activities, both physical and mental, should be carefully limited and directed. The **diet** is of much importance, overfeeding and indulgence in alcoholic beverages being harmful. An exclusive **milk diet** will sometimes prove of great benefit. In any case, the amount of food taken at any one time should be rather moderate and the varieties such as are of easy digestion. In incipient cases moderate and regular **exercise** is beneficial. Sudden and violent exertion is harmful and may be dangerous, but walking on level ground or playing golf, or even riding the bicycle, if hill-climbing is avoided, is proper. In less vigorous persons **massage** is of great value. The **Nauheim system of medicated baths and resisted movements** is excellent for properly selected cases, and in some instances the results have been most fortunate.

Myocardial incompetence without valvular disease is found especially among men who have led very active lives, have taken very little exercise, and have grown very stout. The cardiovascular system and the kid-

neys in such men often give out in the late fifties or early sixties. The degenerative process begins with increased blood-pressure in the intra-abdominal vessels controlled by the splanchnic nerves, extends to the entire vascular system, and strain on the myocardium results. The indication is to lessen the peripheral resistance in the sluggish circulation within the mesenteric vessels. The treatment indicated is **medical gymnastics** consisting of both active and passive movements, according to the degree of myocardial incompetence. One essential principle underlies all such exercise, namely, that the patient must not be allowed to hold his breath, but must breathe regularly and deeply in rhythm with the movements, the object in view being the restoration of the functional integrity of the myocardium. The author's experience warrants him in recommending such gymnastics, believing that they would delay, if not prevent, the onset of cardiac inadequacy. Babcock (Amer. Jour. Med. Sci., Jan., 1909).

With regard to drugs, **iodide of potassium** in moderate doses, such as 10 grains (0.65 Gm.) three times a day, if long continued, may promote the nourishment of the heart. **Iron** and **arsenic** are also suitable tonics. If cardiac failure begins to show itself we must have recourse to tincture of **digitalis**, tincture of **strophanthus**, and **sulphate of sparteine**.

Irritation and restlessness at the outset may be allayed by **camphor monobromide** in doses of from 2 to 5 grains (0.13 to 0.3 Gm.). **Nitroglycerin** is the appropriate remedy for a heart that must be relieved and is incapable of responding to stimulation. Syphilis, known or suspected, calls for **mercury** and **sodium iodide** in small doses frequently repeated. **Strychnine** and **cereus grandiflorus** stimulate the nervous apparatus, but contract the arterioles as well as the heart. In neurotic

types of myocarditis **convallaria majalis** should be tried. Schram (N. Y. Med. Jour., Sept. 28, 1907).

Inasmuch as **strophanthus** does not produce vasoconstriction and raise blood-pressure it serves a valuable purpose at times in cases marked by hypertension. This does not mean that it is necessarily to be preferred to **digitalis** even when the blood-pressure is high, for it is the writer's firm belief that **digitalis** may be used without regard to the degree of blood-pressure, if only it be combined with the administration of a vasodilator. **Strophanthus** is less irritating to the stomach than **digitalis**, and for that reason can often be used when **digitalis** cannot. The superiority of **digitalis** over all other cardiac tonics is apt to give rise to a one-drug policy in the medicinal therapy of heart disease. This is to be discouraged. All drugs will at times fail; the personal equation cannot be eliminated, and there are other excellent drugs (**theobromine**, **sparteine**, etc.) to be tried. A. R. Elliott (Interstate Med. Jour., June, 1910).

In the treatment of myocardial disease, the writer combines small doses of **digitalis** with **bromides**, preferably with **calcium bromide**. In *bradycardia of toxic origin* **strychnine** and **belladonna** were useful. **Colchicum** he used in very large doses in cases of a *gouty* nature. **Thyroid extract** was indicated in the *large heart of myxedema*. **Supra-renal extract** was equally useful in *Graves's disease*. G. A. Gibson (Brit. Med. Jour., Aug. 3, 1912).

Strychnine sulphate long continued in moderate doses may be of marked value in strengthening and regulating the heart. For cases where the amount of urine is very deficient **theobromine sodium salicylate** sometimes works well. It may be given in divided doses to the amount of 60 to 90 grains (4 to 6 Gm.) in twenty-four hours.

In the final stages the treatment is the same as in cardiac dilatation (see below). In most instances it is very unsatisfactory, the heart responding very imperfectly to any therapeutic appeals.

Case in which striking benefit resulted from the intravenous use of **strophanthin** after the failure of all other heart tonics and diuretics. The dose was 0.001 Gm. ($\frac{1}{64}$ grain) injected directly into a vein, at intervals of two or three days, not waiting for compensation to fail entirely. The writer was thus able to keep his patient, a man of 44, in good condition for months, notwithstanding his degenerated myocardium. Flesch (Wiener klin. Woch., Nov. 12, 1908).

Case of an elderly gentleman who had suffered for several years from attacks of vertigo and unconsciousness. Almost daily, sometimes hourly, and even at shorter intervals, the alarming symptoms appeared. The frequency of the pulse was from 27 to 31 beats in the minute; only every second contraction of the heart caused pulsation. All the physicians who saw the case diagnosed, quite correctly, a disorder of the myocardium and treated him accordingly, but without success. The enormously distended abdomen of the patient had not at first been taken into consideration. The reduction of its size, although it did not cure the diseased myocardium, was followed by cessation of the attacks of vertigo and unconsciousness. The size and the weight of the abdomen having been reduced, the work of the heart was materially relieved to such an extent that even the imperfect contractions were sufficient to fill the brain with the necessary amount of blood. In cases of dyspnea caused by heart affection, an **abdominal belt** is of great aid. Rose (N. Y. Med. Jour., May 6, 1911).

Case of a woman aged 66 years, suffering from pronounced circula-

tory weakness due to myocardial degeneration, in which remarkable benefit was derived from the ingestion of large amounts of **cane-sugar**. One ounce morning and evening (later increased to 4 ounces per diem). The pulse became regular, its rate dropped from 110-125 to 88-96 and later to 72-84; the edema and cyanosis disappeared, the patient became alert and active, and finally left the hospital entirely free of discomfort. All the usual cardiants had failed. Sir Robert Simon (Birmingham Med. Rev., May, 1912).

The writer has treated nearly 100 cases of chronic myocarditis in subjects over 65 years of age, including those in the eighties and nineties, with tincture of **camphor**, 10 to 15 drops, used continuously in acute crises, **digitalis** or **pituirrin-adrenalin**. The writer therefore takes issue with Mackenzie when the latter states that camphor is without action on the heart. Zangger (Corresp. bl. f. schweizer Aerzte, Dec. 22, 1917).

HYPERTROPHY OF THE HEART.

DEFINITION.—An increase in the thickness of the walls of the heart which may be general, affecting the entire organ, though more confined to, or predominant in, one side of the heart. The left ventricle is rather more often affected than the right. The amount of muscular tissue in the auricles is scanty even when under the influence of hypertrophic changes.

VARIETIES.—*Simple* hypertrophy is associated with a normal size of the cardiac cavities. *Eccentric* hypertrophy implies enlargement of the cavities as well as thickening of their walls. *Concentric* hypertrophy—thickened walls encroaching on the cavities—is seldom, if ever, met with. (It is said to occur as a congenital condition. Its existence in any particular case should not be affirmed until by prolonged

soaking in water all *rigor mortis* has softened.)

There is a particular group of hypertension cases, in which there is no notable thickening of the superficial arteries and no renal changes of importance. It is common in men and comprises, in the author's experience, a rather large proportion of women of middle age. The patients are usually robust, stout to obese, and past 50 years of age. In men syphilis at times plays a part, but the writer does not think that alcohol is to be blamed. In the majority of cases there had been mental strain and heavy responsibility.

The symptoms complained of were usually respiratory or gastric in nature, rarely such as to direct attention to the heart and vessels. One-half to two-thirds came complaining of indigestion and bloating after meals. A majority of the remainder noticed shortness of breath on exertion. A few were first troubled with vertigo, with numbness and tingling of the extremities, or with ringing in the ears. The heart in these cases is found enlarged, often far beyond what one would expect from either the symptoms or the physical appearance and capacity of the patient, but the radials are either soft as in youth or a trifle thickened, like a thin-walled rubber tube. The urine may not show anything of importance except a slight increase in quantity. These patients pass much larger amounts of urine during the night than in the daytime. The blood-pressure is from 190 to 260 mm. Hg or even more.

The hypertrophy of the heart is not due to valvular disease, though not rarely there is a systolic murmur at the aortic area without concomitant signs of aortic stenosis, the murmur indicating, evidently, sclerosis in the arch of the aorta. These cases are particularly prone to anginal attacks.

The course of the affection is largely governed by the state of the

heart. Death finally results either from total failure of compensation or from angina pectoris, unless some intercurrent malady anticipates these two. Apoplexy occurs only infrequently.

In the treatment, the first and foremost measure is **rest**, mental rest being more important than physical rest, although the latter has its place. The **diet** is of importance, but more from the point of view of quantity than of quality. It may be wise to restrict somewhat the nitrogenous, more particularly the purin-containing foods. The patient should eat a small evening meal. In regard to stimulants, the author is more afraid of tobacco than alcohol, but usually restricts both, as the case may require. The bowels must be kept open. Many get comfort from a pill of **phenolphthalein** and **rhubarb**, or from the well-known **compound licorice powder**. An occasional dose of **calomel** or **blue mass** is useful. A simple hot bath or a short electric cabinet bath may at times be of benefit, but the latter ought not to be left to the uncontrolled discretion of the patient.

As for drugs, the nitrites are to be used only to relieve symptoms. Where **nitroglycerin** fails, **sodium nitrite** in doses of from $\frac{1}{8}$ to 2 or even 3 grains may prove useful. **Erythrol tetranitrate** is a powerful vasodilator in doses of $\frac{1}{2}$ grain (0.03 Gm.), but often produces a painful fullness in the head. The continued use of the nitrites is of doubtful utility unless the pressure is rising, or there is angina pectoris, or marked dyspnea. In such cases they may be given over a long period in large doses. **Sodium iodide** is given two hours after meals, in water or milk. Many patients who are suffering from dyspnea and even from vertigo do well on small doses of **digitalis**. Either the tincture in from 5- to 10-minim (0.3 to 0.6 c.c.) doses three times a day, or the powdered leaves ($\frac{1}{4}$ to 1 grain—0.016 to 0.06 Gm.) is given.

Venesection is undoubtedly at times useful. It is safe to abstract in these cases up to a pint of blood, and if the pressure instrument is kept on the arm and the pressure controlled, one may take off 20 or 24 ounces. The relief from symptoms is often magical. David Riesman (*Amer. Jour. Med. Sci.*, April, 1913).

SYMPTOMS.—It is astonishing how little subjective disturbance may be present, even when the hypertrophy is pronounced. To be sure, the enlargement is an attempt on the part of nature, as we shall see under **ETIOLOGY**, to avert symptoms; yet we wonder how the bulk and strength of the organ can fail, as they often do, to attract its owner's attention. There may be cardiac discomfort, throbbing or heaviness, especially when lying on the left side, but seldom any pain. Sometimes there are signs of cerebral hyperemia: vertigo, tinnitus aurium, flashes of light, headache, and disturbed sleep. In a general way, it is fair to say that the more prominent the subjective symptoms are in any patient, the more likely it is that he has something more than pure hypertrophy: either a merging of the hypertrophy into dilatation or else some neurotic disturbance.

The esophagus may be either dislocated or compressed by the pressure of an enlarged heart. When dislocated the esophagus is displaced to the right and backward; when compressed it is between the vertebral column and the left auricle. These conditions rarely give rise to subjective troubles. Kovacs (*Wiener klin. Woch.*, Oct. 20, 1910).

Objectively, we notice the pulse, the chest wall, the epigastrium, and the heart itself. The pulse is of good strength. It is usually not rapid. Irregularity and intermittence suggest

failing compensation; although both may occur when compensation is perfect.

Inspection shows a forcible, extended, and dislocated cardiac impulse. This may be powerful enough to render the thorax of a young subject asymmetrical, so that the lower part of the sternum and the ribs adjoining it on the left bulge forward. If the left ventricle is mainly affected, the apex is lower than normal and displaced to the left; if the right ventricle, the apex is displaced still more to the left, but it is not lowered. Enlargement of the right ventricle is evidenced also by pulsation in the epigastrium and in some cases at the right edge of the sternum. Universal hypertrophy, as seen in some cases of aortic regurgitation, lowers the apex to the seventh or eighth intercostal space and displaces it to the nipple line, while the whole body jars under its powerful efforts like a small tugboat with a large engine. Upon palpation the apex seems blunter than normal, and its impulse is slow and powerful, contrasting with the rather spiteful tap of dilatation. Sometimes the action of the auricles can be detected by the lightly apposed hand.

The heaving apex impulse is a sign of left ventricular hypertrophy. As evidence of moderate hypertrophy the accentuation of the first sound over the left ventricle, just above the apex, is of considerable importance. Normally, the first sound is less loud over the left ventricle than over the conus of the right ventricle. This accentuation of the first sound was found to be present in cases of hypertrophy following exercise, pregnancy, old age, and associated with obesity, certain valvular lesions, early arteriosclerosis, and nephritis. It was not present in cases of or-

thostatic albuminuria. The weakening of the first sound, so frequently noticed with the heaving impulse of marked hypertrophy, is chiefly a matter of poor sound conduction. Kurt (Wiener klin. Woch., Aug. 12, 1909).

Percussion demonstrates an increased area of dullness, extending a trifle higher than normal, or even up to the second space, but exceeding the normal limits mainly in a lateral direction, one or two fingers' breadths to the right of the sternum, and as far as the nipple or the anterior axillary line on the left. Inasmuch as aortic regurgitation is sometimes associated with dilatation of the aorta, we may in this disease get dullness in the second right interspace at the right edge of the sternum.

The first sound at the apex is dull and loud. It has a booming quality, contrasting with the valvular snap of dilatation. A reduplication of the first sound at the apex (gallop rhythm) is ominous of beginning cardiac debility. At the base the first sound is not heard so distinctly as in dilatation, while the second sound is loud and clear, with strong accentuation of that valve (aortic or pulmonary) which corresponds to the obstruction that the hypertrophy is trying to overcome. For instance, in chronic nephritis the aortic second sound is accentuated, and, in right-sided hypertrophy, the pulmonic. In the presence of valvular lesions it need not be said that the murmurs caused by them more or less modify or replace the physiological sounds.

The tracings of the venous pulsation, which have been generally neglected, are of equal if not superior value to the cardiograms of the ventricle and the sphygmograms of the

arteries. They do not reveal pathological lesions of the right heart, but present well-marked characteristics in certain lesions of the left heart, particularly in hypertrophies of renal origin and in those which accompany aortic insufficiency. Bard (*Semaine méd.*, June 3, 1908).

DIFFERENTIAL DIAGNOSIS.—

Nervous palpitation does not give the sensation of strength in the cardiac impulse, although if long continued it merges into hypertrophy. The sounds are more valvular and have a certain "irritable" character.

Dilatation has a feeble impulse, coming against the chest with a weak slap. The first sound at the apex has less muscular quality than in health, while in hypertrophy the difference is the other way. In other organs we notice signs of failing compensation. There are dullness and moist râles at the base of the lungs or even hydrothorax. The liver is enlarged. Dependent parts are edematous. The urine is scanty, high colored, with an excess of urates and more or less albumin.

Care must be taken not to mistake a displaced heart for an enlarged one, whether the change in position be due to thoracic tumor, pleural effusion, or pressure through the diaphragm. Again, the retraction of the lung because of chronic phthisis or failure to expand after pleurisy may expose a normal heart in an abnormal way. On the other hand, emphysema may mask actual hypertrophy. In a complicated case under my care a left-sided pneumothorax, limited by adhesions, acted similarly.

The area of dullness in pericardial effusion is triangular, with the base downward. That of a generally hypertrophied heart is ovoid. More-

over, the feeble impulse and distant heart sounds would at once exclude hypertrophy.

It is advisable in every case to establish the cause of the hypertrophy. When this can be done it confirms the diagnosis,—besides having a possible influence upon treatment.

ETIOLOGY.—Hypertrophy results from increased demands upon the circulation. An essential condition for its development is a fair degree of cardiac and systemic nutrition. A patient far advanced in phthisis cannot develop hypertrophy, nor will greatly occluded coronary arteries supply to the myocardium the requisite material for new growth. The causes of hypertrophy may be enumerated as follows:—

1. Obstruction to the general circulation, as occasioned by coarctation of the aorta, hypoplasia of that vessel, or compression of it by deformed chest walls or tumors.

Aneurism might be expected to cause hypertrophy, but it seldom does, unless associated with aortic regurgitation. Atheroma of the aorta is set down as productive of hypertrophy. It embarrasses the heart because it increases the friction of the blood-current and diminishes the elasticity of the artery. Conversely, hypertrophy tends to produce atheroma by maintaining a high arterial pressure, so that the two conditions are apt to coexist. Other things which increase the labors of the left ventricle and enlarge it are arteriosclerosis, acute and chronic nephritis, and, to a certain extent, pregnancy.

The writer has compared the weights of the hearts of normal rabbits with the weights of the hearts from rabbits which had received repeated injections of adrenalin. Since the actual weights of the heart of

rabbits varied within wide limits it was only possible to use the relative weight of the heart to the body weight. This figure was fairly constant. In all the rabbits inoculated with adrenalin, hypertrophy of the heart was found, and the hypertrophy affected almost exclusively the left ventricle. There was no constant relationship between the numbers of injections of adrenalin and the amount of cardiac hypertrophy; and well-marked hypertrophy occurred after comparatively few injections. Miesoviez (*Wiener klin. Woch.*, Bd. xxii, S. 79, 1909).

There occurs regularly in rabbits, after the injection of adrenalin, myocardic lesions of the left ventricle. These lesions can be seen with the naked eye, occur early, and appear to be more constant and characteristic for the injections of adrenalin than the arterial lesions. They consist in an hypertrophy of the muscle-fibers with increase in the number of muscle-nuclei, and indistinctness of cross-striæ, increase in the connective tissue, which occurs early, and degenerative processes affecting the muscle-fibers, which become especially marked at a somewhat later stage.

The writers call attention to the analogy which exists between these lesions and the changes described in hypertrophied hearts in man. Loeb and Fleischer (*Jour. Exper. Med.*, x, 1909).

There is considerable evidence to prove that it is lack of the blood-pressure-raising substance, constantly present in sound kidneys, which is responsible for the hypertrophy of the heart in kidney disease. Either other organs work vicariously and to excess to supply this lacking physiological substance, or some inhibiting action from some other direction is lacking. In studying the subject, a number of other organs should be taken into consideration, besides the suprarenals. Senator (*Zeit. f. klin. Med.*, Bd. lxxii, Nu. 3-4, 1911).

2. A second class of the causes of hypertrophy includes those conditions which obstruct the lesser or pulmonary circulation, viz., tumors, excessive pleural effusion, emphysema, chronic interstitial pneumonia, and some cases of phthisis. Orth states that some cases of chronic bronchitis exhibit a degree of hypertrophy of the right ventricle not accounted for by the amount of emphysema present.

3. Valvular lesions are sure to cause hypertrophy unless the patient is too feeble, or unless he is overwhelmed by the shock of their sudden development, as, for example, when a cusp of the aortic valves is torn off by violent exertion. More will be said about the valves under *PATHOLOGY*. Chronic adhesive pericarditis causes hypertrophy, particularly when, besides the obliteration of the pericardial space, there is adhesion of the outer surface of the pericardium to the pleura. Interstitial myocarditis is another cause.

4. Long-continued and severe muscular exertion—as exemplified in blacksmiths, iron-molders, coal-miners, and longshoremen—may endanger the heart; also prolonged or habitual mental excitement or worry, to some extent.

5. Somewhat allied to the preceding causes are exophthalmic goiter and excess in tea, coffee, tobacco, alcohol, and venery. Sometimes more than one cause operate in a single person. Laborious occupations affect much more severely the free drinkers than the total abstainers. Brewery workmen illustrate this; although it may be that the effect of beer is due not merely to the alcohol it contains, but also to the large amount of liquid and to the carbohydrates dissolved in it, which would, in an excessive drinker, tend to keep the arteries at rather high tension.

PATHOLOGY.—The muscular fibers of an hypertrophied heart are increased in size somewhat, but mainly increased in number. Macroscopically, the cut surface is red and firm. The extent of the hypertrophy can be determined by the size of the organ, the thickness of its walls, and its weight. A normal heart should be of about the same bulk as the closed fist of the sub-

prove deceptive as to the existence or not of hypertrophy in cases of eccentric hypertrophy, because the walls may look relatively thin and yet be absolutely hypertrophied. Weighing is a valuable procedure. The normal heart weighs 8 or 9 ounces. In disease the organ may weigh 1 or 1½ pounds, and exceptionally 3 pounds, *i.e.*, as much as the liver!

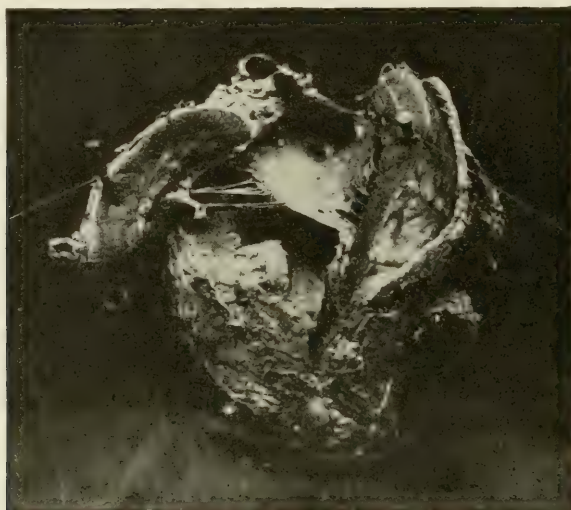


Fig. 1.—Eccentric hypertrophy due to adhesive pericarditis.

ject. The wall of the normal left ventricle is about ½ inch in thickness, and of the right ¼ inch, or a little less. The left ventricle seldom attains the thickness of 1 inch; the right may reach ¾ inch, and it has been reported as being even more than an inch in thickness. The auricles are never very thick. The left in health is about ⅛ inch and may become ¼ inch when hypertrophied. The right auricle is still thinner, and shows its tendency to hypertrophy by changes in its auricular appendix rather than in the rest of its cavity. Before measuring the walls, *rigor mortis* should be relaxed, as already advised, by soaking in water. Mere inspection may

[*Description of Cuts.*—Fig. 1. Eccentric hypertrophy as a result of chronic adhesive pericarditis in a man aged 26 years. Weight of heart with pericardium, 1328 Gm. (44 ounces). Valves competent. Wall of left ventricle, 2½ cm. thick; of right ventricle, 5 mm. Patient of Dr. F. C. Shattuck, at one time under the care of the writer. Specimen due to the courtesy of Dr. J. H. Wright.

Fig. 2. Boy aged 6 years in the writer's wards with eccentric hypertrophy due to mitral regurgitation. The black line indicates the extent of cardiac dullness. Two attempts to obtain a radiograph were unsuccessful. HERMAN F. VICKERY.]

Of course, the immediate effect of any of the causes of hypertrophy is manifest in the corresponding portion of the heart, and not in the whole

organ. Aortic stenosis and regurgitation enlarge the left ventricle. In time, however, stasis is produced in the pulmonary circulation, and the right ventricle also hypertrophies. Valvular lesions, whether regurgitant or obstructive, cause an appropriate part of the heart to hypertrophy, and then, sooner or later, more or less directly (with one exception) entail increased labor upon all the other portions of the heart. The exception is mitral stenosis, which affects the left auricle, the right ventricle, and the right auricle, and then tends to cause stasis in the general venous return, with consequent obstruction to the outflow of blood from the left ventricle and aorta into the arterial capillaries; but this obstruction to the expulsive efforts of the left ventricle does not result in hypertrophy of that portion of the heart, because so little blood is admitted into it through the stenosed mitral valve.

Hypertrophy induced by the production of aortic insufficiency involves all the chambers of the heart. The greatest absolute increase in weight is in the left ventricle. The remaining segments, arranged in the order of decreasing increments, are septum, right ventricle, and auricles. The greatest relative increase is also in the left ventricle, but the auricles show a relative hypertrophy greater than that of the septum or right ventricle. The co-hypertrophy of the auricle is not due to an altered venous pressure, but results from an increased force of auricular systole. The heart shows an increase in weight within one week after the production of aortic insufficiency. H. A. Stewart (Jour. of Exper. Med., Feb., 1911).

The greatest hypertrophy occurs in aortic regurgitation (*cor bovinum*). There is first eccentric hypertrophy of the left ventricle. When this reaches

sufficient size, there arises relative insufficiency of the mitral valves, and thereupon hypertrophy of the left auricle and the right side of the heart.

The inevitable result of hypertrophy is eventual debility and failure. By the time of death dilatation may far surpass hypertrophy; or the hypertrophied muscle may be more or less changed by fatty degeneration.

PROGNOSIS.—As just stated, the condition must terminate unfavorably. So long, however, as the hypertrophy compensates for the obstacle which



Fig. 2.—Eccentric hypertrophy due to mitral regurgitation.

rises to it, or grows proportionally with any augmentation of that obstacle, the patient may feel perfectly well. Even during this time of perfect compensation he may, however, suffer from cerebral hemorrhage or (if the hypertrophy affects the right ventricle) pulmonary hemorrhage. Escaping these dangers, he may do well for years, but finally dies, either from dilatation or fatty degeneration or the failure of innervation already mentioned.

TREATMENT.—The care of a patient with hypertrophy demands that we should allow nothing to aggravate the condition, and should in every way possible promote the nutrition of the myocardium. The etiology must be

considered. Tobacco and alcohol must be forbidden and excitement and worry averted. Simple, nutritious food should be taken regularly in moderate quantity. It would be better to permit lunches than the ingestion of a large amount at one time. Moderate and habitual **exercise** is beneficial. The exact amount and character may be determined partly by the experience of the patient; dyspnea and palpitation are not to be caused by it. If there is discomfort and throbbing in the left chest, **bromides** may be useful, or a drop or two of tincture of **aconite**, or **veratrum viride**, thrice daily. In a stout patient an occasional **saline purge** may be useful.

A daily **cool bath**, with **rubbing**, is a good tonic. Hot baths and Turkish baths are unfavorable or dangerous.

In overhypertrophy of the heart direct depressants (aconite, etc.) are rarely needed. The more concentrated forms of food should be used very sparingly, and the daily quantity should be slightly less than that required in health. Tea, coffee, alcohol, and smoking must be prohibited. **Physical exercise** should be of the gentlest sort; if the patient's occupation tends to stimulate the heart, it must be immediately abandoned. A mild saline purge (3ij to 5ss—8 Gm. to 15 Gm.—of **Rochelle salts** once daily) is beneficial.

For relief of vertigo, head fullness, and precordial discomfort, particularly when arteriosclerosis is a traceable cause, **nitroglycerin** in full doses and **veratrum viride** are most useful; the efficacy of both may often be enhanced by the **bromides**. In nervous cases the bromides, with **valerian**, are the most valuable agents. Nothing, however, is more important than the determination and removal of the cause when possible. J. M. Anders ("Textbook of the Practice of Medicine," 1913).

DILATATION OF THE HEART.

DEFINITION.—Increase in the size of the heart, due to enlargement of one or more of its cavities. Clinically, "dilatation" is applied to an enlarged, but failing, heart displaying the phenomena of "ruptured compensation." However, dilatation may be either useful, *i.e.*, compensatory, or harmful. When the heart is called upon to do more work, it is aided in its efforts not only by the hypertrophy of the muscle, but also by the enlargement of the cavity upon which the stress of the work falls, for in this way a larger amount of blood is pumped out of the heart with each systole. As long as the hypertrophy keeps pace with the dilatation, the latter is advantageous. When dilatation develops more rapidly than hypertrophy, symptoms of broken compensation occur.

VARIETIES.—"Simple" dilatation is the term used to denote that condition in which the walls of the heart remain of comparatively normal thickness. Inasmuch, however, as the cavities, and consequently their walls, are more extensive than normal, simple dilatation is associated with a certain amount of hypertrophy. Dilatation is "hypertrophic" when the heart walls are thicker than normal. Another name is "active dilatation," and viewed from the opposite standpoint it becomes "eccentric hypertrophy." In "atrophic" or "passive dilatation" the walls are thinner than normal.

Most cases of dilatation are essentially chronic in their development and progress. Some, however, are acute.

SYMPTOMS.—Usually the earliest indication to the patient of his trouble is shortness of breath. This at first is apparent only upon exertion, but

in well-developed cases it becomes a source of great suffering. Hardly more than one word can be uttered without a pause for breath, and sleep, if obtained at all, is possible only in the vertical position (orthopnea). The ordinary automatic respiration has sometimes to be supplemented by voluntary efforts; so that when sleep does come the dyspnea becomes aggravated and soon wakes the patient.

The first evidence of cardiac involvement in infectious diseases is revealed by changes in the first sound heard at the apex and by diminished tension in the arteries. If the loss of cardiac tone is sufficiently great, dilatation follows. This is characterized by irritability of the heart, softness, weakness, and irregularity of the pulse. Symptoms of failing circulation depend on the degree of muscular weakness and extent of dilatation. A dilatation outward to one finger's breadth beyond the nipple line is usually recovered from; two fingers' breadth is exceedingly dangerous; and three fingers' breadth is usually fatal. Vomiting in a case of dilatation is usually the precursor of sudden death. All patients with infectious diseases should be carefully watched and appropriate measures taken to reduce the work of the heart to a minimum, prevent strain, and eliminate toxins as rapidly as possible before symptoms of heart-failure threaten or are present. In every case of infectious disease the heart should be frequently examined until convalescence is fully established. J. E. Blake (N. Y. State Jour. of Med., Nov., 1907).

Another early symptom is palpitation with a sense of discomfort or oppression in the cardiac region. It is singular that the powerful heave of an hypertrophied heart does not seem to obtrude itself upon the consciousness of the patient so much as the feeble flutter of dilatation.

There may also be a cough, with white, frothy, serous expectoration. The imperfect circulation in the brain is evidenced by more or less mental slowness and easy fatigue, with impaired memory, drowsiness, despondency, ill temper, and attacks of faintness. In the digestive tract the passive congestion of the stomach is evidenced by fermentation, heaviness, nausea, and even vomiting. The bowels are usually sluggish, and the urine is scanty and high colored, with a deposit of urates.

In mild degrees of dilatation the complexion is pale; in more advanced cases, dusky or cyanotic, with blue lips and finger-nails. The extremities are apt to be cold to the touch, and the sluggishness of the capillary circulation is illustrated by the slow return of color to any point of the surface after firm pressure: the shape of the examiner's hand is, as it were, stenciled upon the cyanotic surface. The labored breathing is noticed even while the patient is at rest, but becomes striking upon the least exertion. Edema appears first in the ankles, thence creeps upward to the thighs and pudenda, and finally invades even the face and arms. Ascites and hydrothorax are often present. It is not unusual to find a considerable amount of fluid in one side of the chest, usually the right, while the other presents merely the signs of edema. The eyes are somewhat prominent and glassy. Frequently the liver is painful, tender on pressure and much enlarged, reaching even to the level of the navel. This change in its size may be more or less obscured by the ascites present, but in that case can often be demonstrated by a quick, though gentle, pressure of the fingers inward ("dipping"). In some cases the spleen is also found to be enlarged.

To detect enlargement of the heart an examination with the fluoroscope may quickly clear up the diagnosis, according to the writer. An orthodiagram or a teleoroentgenogram may also show slight abnormality in the outline or measurements of the heart. G. C. Shattuck (Boston Med. and Surg. Jour., Mar. 16, 1916).

The writer describes, under the term *adrenal asystole*, a syndrome characterized by a large heart with low arterial pressure. In 4 cases described the adrenals were found extremely small or diseased. Drawing the finger or a stick along the skin leaves a white mark instead of the usual red mark. There is often complete arrhythmia and auricular fibrillation, with more or less dyspnea. Digitalis had little effect in these cases, but **adrenal gland** had a manifest beneficial action. Used early and systematically, it can ward off or retard the otherwise inevitable fatal termination. Josué (Paris méd., July 11, 1916).

The pulse is of great importance in regard both to diagnosis and prognosis. It is apt to be frequent, ill sustained, and irregular in force and rhythm. The number of radial pulsations may be considerably less than the number of heartbeats as counted with the stethoscope. The pulse-wave is apt to be small, but in cases where previous high tension, or arteriosclerosis, has dilated the peripheral arteries the wave may be of considerable volume.

The phenomenon known as bigeminal pulse is quite frequent in cases of dilatation. Often the second and weaker of these twin cardiac impulses fails to reach the radius in perceptible strength. Inspection of the cardiac region shows no such bulging as may be present in cases of hypertrophy, except when the precedent hypertrophy has left its traces behind it. It may be difficult to locate the apex-beat by the eye, or the impulse

may seem to be diffuse and not to impinge upon exactly the same point with every beat.

Over other portions of the heart than the apex the intercostal spaces may sometimes be seen to protrude and recede with the action of the heart, and sometimes an extensive wavy motion may be observed over the cardiac area. When the right ventricle is dilated, there is sometimes a marked impulse in the epigastrium below and to the right of the xiphoid cartilage.

Upon palpation the heart beat is found not to be of a strong and heaving character, but feeble and resembling a quick tapping or slapping of the chest, sometimes with more or less of a tremulous sensation imparted to the hand. Even when the eye has detected the apex beat, the hand may not be able to distinguish it. The most satisfactory mode of practising palpation is by resting the whole hand, as lightly as possible, over the precordium, and then testing the impressions thus received by firmer pressure and by digital touch.

Percussion shows an increase in the area of cardiac dullness varying somewhat according to the portion or portions of the heart mainly dilated. Increase in the size of the right ventricle makes the heart broader than normal, but not much longer. The right limit of dullness may, in such a case, reach or even extend beyond the right nipple. Enlargement of the right auricle is associated with increase of dullness at the right edge of the sternum, corresponding to the second and third intercostal spaces. According to Harris, in dilatation due to mitral stenosis all dullness to the right of the sternum is due to enlargement of the right auricle. The dilated left ventricle presents an area of

cardiac dullness not much wider toward the right than normal, but extending downward to the seventh or eighth intercostal space, and perhaps an inch or two to the left of the normal position of the apex.

By means of auscultation we may, in the first place, be able more exactly to locate the position of the apex-beat than by either inspection or palpation, assuming that it corresponds to that point where the first sound of the heart is loudest. The first sound of the heart in cases of dilatation may be louder than normal, but it is devoid of muscular quality, being short and valvular; that is, closely resembling the normal second sound of the heart. It is heard with more distinctness in the aortic area than is the first sound of the hypertrophied heart. Frequently there is also heard a systolic murmur at the apex, due to regurgitation through the mitral valve or tricuspid, because the auriculoventricular opening is dilated as well as the ventricle, and consequently has become too large for the valve, even though normal, to close it efficiently (relative insufficiency). The second sounds at the base of the heart are of variable character in different cases. If they are tolerably sharp and distinct they are somewhat reassuring, as indicating that the ventricles still possess muscular power. Another important point (W. H. and J. F. H. Broadbent) is the length of the pause between the first and second sounds of the heart as compared with the pause separating one cardiac cycle from another. If the first and second sounds are separated by a shorter interval than in health, we must infer that the dilated ventricles are able to make only an ineffective effort at systole, while, if there is a longer pause between the first and second sounds of

the heart, it is evident that the cardiac muscle still possesses sufficient vigor to make a prolonged effort to overcome the obstacles which it meets in propelling the blood-current.

Extension of the limits of cardiac dullness is always due either to hypertrophy or to a change in the position of the heart. Post-mortem hearts, whose cavities seem to be dilated, are an illusion, due to the fact that cavities whose walls are gaping always appear larger than those that collapse. Besides, normal hearts may be of different dimensions, one being even more than double the size of another. Wachenfeld (*Med. Rec.*, March 7, 1908).

When tricuspid regurgitation exists, the veins in the neck are dark and turgid. Their valves show like knots. Often actual pulsation in them may be demonstrated, especially if the patient takes a horizontal position. Pressure upon the congested liver magnifies the engorgement of the jugulars. Compression and extreme displacement of the esophagus is also liable to occur.

In the case described, a man of 40 fell from a height, and this was followed by acute dilatation of the heart, with edema. Under *digitalis* the symptoms gradually subsided and by the seventeenth day, the condition was normal. Sarachaga (*Revista de Medicina Cir. Pract.*, Jan. 7, 1919).

DIAGNOSIS.—From pure hypertrophy dilatation can be clearly distinguished by the general aspect of the patient, and the evidences of imperfect and failing circulation already detailed. In both conditions the area of cardiac dullness is increased, but in dilatation we do not observe the strong heaving impulse of hypertrophy. In general, it may be said that the two are opposites. Hypertrophy is an exaggeration of the normal state, while dilatation is a condition of weakness and failure.

The first sound of the hypertrophied heart at the apex may not be so loud or distinct as in dilatation, being low and muffled, and, as already stated, it may be inaudible at the base; but there is present in it a muscular quality, distinguishable in a less degree over the apex of a normal heart, and not heard in cases of dilatation.

The hypertrophied heart must at last, however, enter into the state of dilatation,—unless its owner is the victim of intercurrent disease,—and the important practical question for diagnosis in most cases is to determine what degree of deterioration has already been reached and how much longer the circulation can be maintained.

Very valuable information in doubtful cases with regard to the integrity or otherwise of an enlarged heart may be obtained by causing the subject under examination to make somewhat brisk muscular exertion, as by ascending and descending a flight of stairs or by hopping six or eight yards upon one foot. The degenerated heart will become unnaturally accelerated and irregular, while a well-nourished heart will act even better than before.

In certain cases retraction of the lung, as in chronic phthisis, leaves a comparatively normal heart more exposed than in health and might occasion a mistake of the condition for one of dilatation. Factors in this diagnosis would be the history of the case, the signs of pulmonary disease, the absence of venous stasis in other parts of the body, and the fact that the border of the lung near the heart does not extend inward over the cardiac area on full inspiration, as under normal conditions it should.

Mediastinal tumors may cause dullness in the cardiac region, but they are apt to extend upward and to the right or

left side, and the heart sounds are not audible over them in the same way as over the dilated heart. In thoracic aneurism we should expect to find a heaving impulse in the neighborhood of the base of the heart, with other positive signs of aneurism and without the changes in the cardiac sounds and impulse or in the general circulation seen in dilatation.

A more difficult question is to distinguish pericardial effusion from cardiac dilatation. In certain cases this seems to the writer almost impossible, although in the great majority of instances a definite conclusion can undoubtedly be reached. Dullness above the third rib suggests the possibility of pericardial effusion. In pericarditis we are more apt to have a history of an acute onset with fever, pain, and pericardial friction sounds, and perhaps, also, knowledge of a nephritis, or tuberculosis, or acute pneumonia as etiological factors in the production of pericarditis.

In both cardiac dilatation and pericarditis with effusion the right lobe of the liver is depressed, but in dilatation, owing to displacement of the bony thorax, an apparently normal or elevated position of the liver may be found. Hence, in cardiac dilatation high liver dullness is present; in pericarditis with effusion, low liver dullness; and in each a narrow band of relative lung-liver dullness. Calvert (*Archives of Intern. Med.*, Feb., 1909).

The pericardial effusions give an area of dullness somewhat more pear-shaped than that seen in dilatation of the heart, which is, more or less, quadrilateral.

The angle formed by the right border of cardiac dullness and the upper border of liver dullness is acute in health. In this condition it is usually obtuse, but a dilated right ventricle may cause a similar dull-

ness. The left border of cardiac dullness does not correspond with the apex impulse, but is farther to the left. In the left back at the angle of the scapula there may be a small area of dullness and bronchial breathing. Pericardial effusion also raises the apex beat upward and outward toward the third or fourth spaces in the neighborhood of the left nipple, and it renders the heart sounds less distinctly audible than in dilatation. It may also cause a paradoxical pulse. Yet, in case of valvular heart disease with a fresh attack of rheumatism, a recent pericarditis friction sound, and evident failure of compensation, it may be very difficult to determine whether the increased area of dullness on the right side of the sternum is referable to pericardial effusion or to dilatation of the right ventricle, particularly as the dilatation often develops with great rapidity.

In the cases already spoken of there has been a question of mistaking the enlarged area of dullness in the cardiac region due to other causes for a dilated heart. There is a contrary danger in cases of emphysema that a dilated heart may not be recognized because of unnatural pulmonary resonance encroaching upon the true cardiac area. Here we may be saved from error by the history of chronic bronchitis, and of already established and slowly increasing dyspnea, as well as by the characteristic pulmonary signs. Also, the Röntgen ray may be employed.

The following conditions may simulate enlargement of the heart: When for any reason the heart lies more horizontally, it always slides toward the left; the area of dullness and the apex beat suggest enlargement, and a systolic murmur corroborates this. These phenomena are probably caused by the kinking of

the heart in respect to the ascending aorta and the eddy in the blood at the point of the kinking. The most common cause of this horizontal attitude of the heart is the pushing up of the diaphragm. The heart slips toward the left no matter whether the right or the left side of the diaphragm is lifted. Many causes may push up the diaphragm, and it may induce a number of subjective symptoms and even lead to extrasystoles. Herz (*Jour. Amer. Med. Assoc.*, from *Med. Klinik*, May 24, 1908).

The writer describes cases of cardiac dilatation which gave no signs of decompensation, and observed usually in healthy individuals. The prominent symptoms are those of cardiac irritability, fatigue or possibly exhaustion. It is often noted in young and well developed individuals, *e.g.*, in athletes. The chief and sometimes only complaints are shortness of breath on exertion, precordial pain, fatigue and palpitation. Frequently there is only fatigue on the least exertion. Vasomotor changes, blanching of the face, cold hands, paleness around the mouth, giddiness and faintness sometimes occur. Symptoms of neurasthenia are often prominent and misleading. They invariably have low blood- and pulse-pressure. Overwork, worry, strain, overindulgence and emotion are contributing factors. E. P. Bundy (*Jour. Amer. Med. Assoc.*, June 24, 1916).

ETIOLOGY.—Increase in the cavities of the heart must be due either to abnormal weakness of their walls or excessive labor in the propulsion of the blood-current. Among obstacles to the circulation should be enumerated valvular disease, arteriosclerosis, chronic interstitial nephritis, atheroma, obesity, emphysema, and congenital narrowness of the aorta. Contrary to what might be presupposed, thoracic aneurism does not cause change in the heart walls, unless associated with aortic regurgitation. Pericardial ad-

hesions may cause dilatation of the heart, more especially when the outer surface of the pericardium is fastened to the chest wall or diaphragm.

Dilatation of the heart results from one of the following factors: (1) an increase in the amount of work to be done by the heart, as in chronic nephritis, valvular disease, etc.; (2) an impairment of the power of the myocardium from degenerative changes, toxic conditions, etc.; (3) failure of the cardiac muscular tone, as in severe nervous shock, etc. The symptoms are sleeplessness, dyspnea, edema of the lungs, congestions of abdominal organs, and the resulting consequences. The diagnosis is made from the foregoing symptoms and from the throbbing in the precordium, the distention and pulsation of the jugulars, and the increased cardiac fullness. This condition must be distinguished from simple hypertrophy and pericardial effusion. In attempting to relieve this condition the two cardinal points to be considered are: (1) to lessen the amount of work which is required of the heart and (2) to increase the power of the heart to do its work. The first is accomplished by bodily and mental rest, light diet, purgation, relaxing the peripheral vessels, and bleeding; the second by administration of cardiac stimulants, baths, judicious exercise, etc. Clayton (*Amer. Jour. Med. Sci.*, Nov., 1907).

Exophthalmic goiter and tachycardia cause cardiac dilatation and, according to some writers, excesses in tobacco and venery, great anxiety and despondency, leukemia, anemia, and chlorosis.

Habitual, severe, and sustained physical exertion may eventuate in cardiac dilatation, as seen in both athletes and in men following laborious occupations. Dilatation may, indeed, ensue upon a single violent or prolonged muscular effort. In many cases of this sort it is

presumable that the myocardium was previously in a vulnerable condition; but yet dilatation may occur in young and apparently healthy men after mountain-climbing, and, after a period of due rest, be completely recovered from. In other cases, however, especially in persons with less elasticity of constitution, the lesion is a permanent one and progresses to a fatal termination. The danger of engaging in athletic competitions without proper training is obvious.

Is it possible for a sound heart in a healthy person to become suddenly dilated as a result of overexertion and then to subside rapidly again to normal? The writer reviews the recent literature on the subject of physical exertion and its effects on the heart as studied by various measures, including radioscapy. All this evidence is rather against the possibility of physical exertion producing acute dilatation of a sound heart in healthy individuals. On the other hand, the evidence shows that this is liable to occur in case of sudden emotional stress, especially in neurasthenics. The writer has already shown that emotional stress, intense anxiety, was able to induce the development of acute organic affections of the nervous system; somewhat the same mechanism explains the acute dilatation of the heart observed in apparently healthy individuals. Marmorstein reported last year 2 such cases caused by the rioting at Odessa. The patients were Jews, and the emotional shock at the spectacle of murder and pillage in their homes induced acute dilatation of the heart, which subsided after a few hours. Both of these patients had a history of neurasthenia. The cases resemble those related by Kress in which acute dilatation of the heart was observed in 2 neurasthenics in the course of transient psychic disturbances. It is also possible that the moral shock has, further, a direct action on the

centers regulating the innervation of the heart and vessels.¹⁴ Cheinisse (*Semaine méd.*, xxvii, No. 9, 1907).

Bodily overexertions which are carried so far as to produce a palpitation of the heart that can be felt, together with a severe dyspnea, will finally result in acute dilatation of the heart. Schott (*Münch. med. Woch.*, May 5, 1908).

Other causes are: acute nephritis, as after scarlet fever; rheumatic pericarditis and myocarditis, pneumonia, and typhoid fever. Influenza certainly may precipitate dilatation, if it does not actually cause it. Diphtheria is a prolific cause of dilatation owing to infection of the myocardium.

The writer has examined 47 out of 65 diphtheria patients with the aid of Moritz's orthodiagraph, the subjects reclining, and found that 20 of these 47 presented evidences of myocarditic phenomena. In 15 of this group (75 per cent. of the cases of myocarditis and 32 per cent. of the total number), dilatation of the heart was unmistakably apparent when examined with the orthodiagraph. The myocarditis of diphtheria made its appearance in the first half of the second week of the disease. It entails a gradual dilatation of the heart, accompanying the progress of the myocarditis and reaching its acme with the height of the latter, usually in the third week, sometimes even before the pulse shows any irregularity. It is generally accompanied by a diffuse apex beat, visible heart beat in the second, fourth, or seventh interspace, with accentuation of the second pulmonary sound, and frequently with a blowing systolic murmur. This dilatation generally retrogresses, mostly by the fourth week, from eight to fourteen days after it has reached its height. The retrogression was complete in only 2 out of the 14 cases; in the others the heart merely retrogressed to about half of the dilatation. Any further subsidence after the children had

been dismissed was not followed. The changes in the pulse are no criterion as to the extent of the dilatation, and slight degrees of the latter escape detection by percussion. H. Dietlen (*Münch. med. Woch.*, April 11, 1905).

Acute cardiac dilatation may be divided into three varieties: 1. The cardiac dilatation which shows itself during the course of some acute infectious disease. 2. The cardiac dilatation of nervous origin, due primarily many times to the wear and tear of an anxious and worrying life, but in which the strain falls far more directly on the brain and nervous system generally than on the muscular make-up of the body. 3. The rapid or sudden cardiac dilatation which comes to those whose excesses in eating or drinking or the use of tobacco are notable and long continued, and who are unable to bear even temporary physical strain without experiencing painful threatening or alarming effects which become manifest very soon or immediately after the exertion. Beverley Robinson (*Amer. Jour. Med. Sci.*, Feb., 1907).

The heart may be invaded by the specific organisms in rheumatic fever, pneumonia, typhoid fever, diphtheria, erysipelas, influenza, and the various septic infections. The results of such invasion are shown in the occurrence of endocarditis, myocarditis, and pericarditis. In these cases the tonicity of the poisoned heart muscle fails and thus dilatation takes place. There are many other conditions in which the heart is poisoned by toxins generated in the patient's body. Series of cases showing that toxins generated from micro-organisms in decayed teeth act in this way. Davy (*Lancet*, June 22, 1912).

High tension in the systemic arteries, aortic stenosis, and aortic regurgitation cause a predominant change in the left ventricle as compared with the other cavities.

In aortic regurgitation the dilatation is beneficial within certain limits. Inasmuch as a certain portion of the blood forced into the aorta with each systole is at once allowed to return to the ventricle, the total amount of blood forced out with the systole must be greater than in health, or there will inevitably

ever, is enlargement of the right side of the heart: at first of the right ventricle, and, when it begins to fail, also of the right auricle. The right auricle seldom undergoes much hypertrophy; any increase in its size is apt to be a pure dilatation.

The stress of mitral stenosis, pulmo-

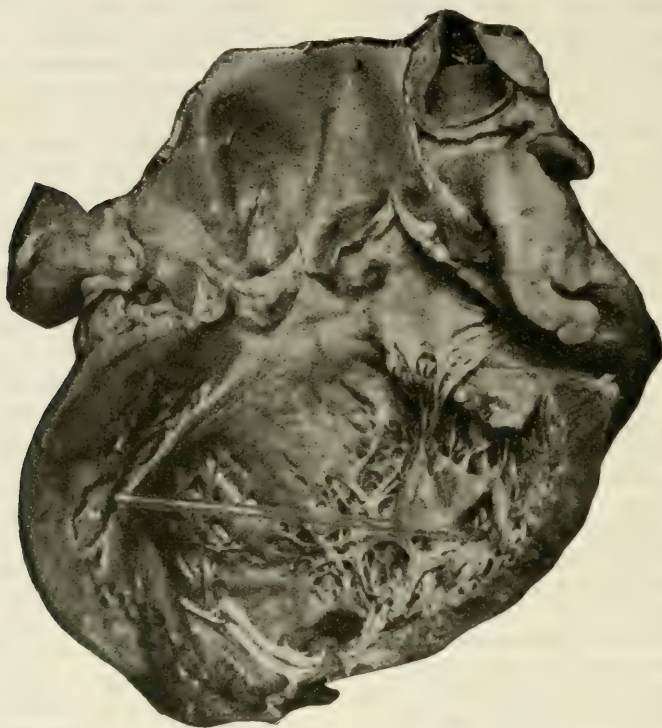


Fig. 1.—Dilated left ventricle with a cardiac aneurism at apex. Case of chronic interstitial myocarditis in a man aged 84.

be a diminution in the normal amount in the arterial system. In its final development aortic insufficiency presents dilatation of all the cavities of the heart. In case of mitral regurgitation there is also dilatation of the left ventricle, because a leak in the mitral valve during systole overdistends the left auricle, and during diastole the blood rushes into the left ventricle under more than normal tension, enlarging its cavity. The usual and chief effect of mitral lesions, how-

ever, is enlargement of the right side of the heart. Predominant dilatation of the right ventricle makes the heart globular in shape. The enlarged right ventricle overlaps the left ventricle, except at the left border of the heart.

An examination of the minute structure of the myocardium in dilatation may show either interstitial myocarditis or fatty degeneration, or there may be no change in the heart-fibers appreciable

even with the microscope. In certain of these cases it would seem probable that the nervous ganglia connected with the heart may be at fault. In marked dilatation the pectinate muscles themselves are flattened into mere tendinous cords.

[The accompanying illustrations are from photographs of specimens in the Warren Museum in the Harvard Medical School, for advice and assistance in ob-

to the liver and digestive tract. Each case should, therefore, be carefully considered on its own merits or demerits.

The most acute transitory form of dilatation is probably that which occurs in athletes and others under great or long-continued effort. The majority of these persons, if in good health and well trained, seem to escape permanent injury. It will be found, however, that

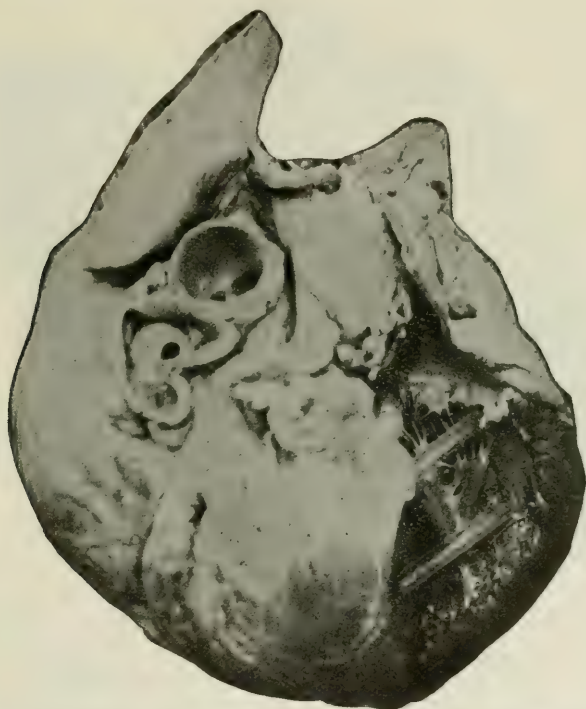


Fig. 2.—Excessive dilatation, with hypertrophy, of the right ventricle. Valves of pulmonary artery united to form a smooth fibrous diaphragm with a small opening in the center. Left ventricle laid open, not enlarged. Case of a boy aged 14. Cyanosis, dyspnea, sudden death.

taining which I am indebted to the courtesy of Dr. William F. Whitney, Curator. HERMAN F. VICKERY.]

PROGNOSIS.—It will be seen from what has gone before that dilatation of the heart is a condition in which it is not proper to generalize when considering any individual case. The state might be said to bear the same relation to heart conditions that jaundice holds

a certain important proportion of those who engage in violent and desperate competitive physical exertions, as, for instance, a long boat race, suffer for years thereafter from discomfort in the cardiac region, with some tendency to irregularity of the pulse.

Those who train athletes should appreciate this possibility. The first degree of dilatation and consequent venous

stasis is shown by pallor, for this reason: as the left ventricle becomes tired, blood accumulates in the right side of the heart and the systemic veins in more than normal amount, yet not exceeding the capacity of the venous system. As a consequence of this increase of blood in the venous channels, there is less blood than normal in the arteries, causing a pallor which does not advance to

and effect one way or the other, but special sense centers and heart both giddy together as the result of some deep-seated central nerve storm or degeneration. Goodhart (*Lancet*, Dec. 3, 1910).

With regard to the more common and usually slowly developing forms of dilatation, it should be said that there may be many degrees of the disease in different persons. Here, too, sudden prog-

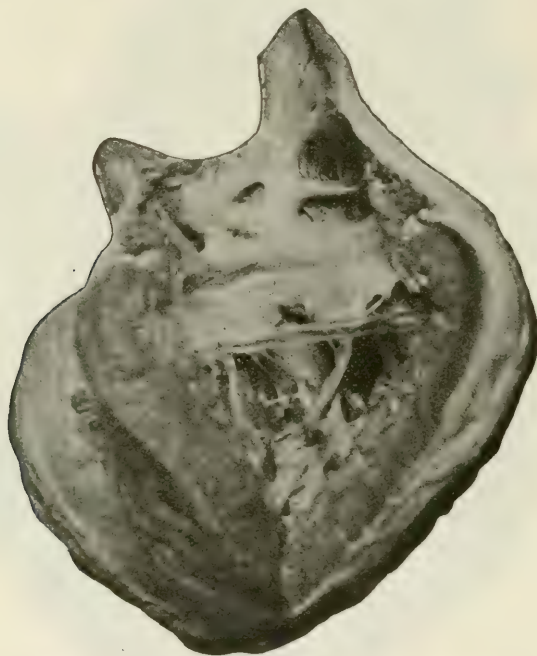


Fig. 3.—View of the right ventricle of the same heart.

cyanosis until a much greater amount of blood is present in the veins. If, then, a person engaged in vigorous exercise changes from the ordinary pink flush of countenance to a decided pallor, the limit of safe exertion has been reached. Cyanosis conveys a still more imperative warning.

Some cases of heart strain and dilatation are not due to an essential muscle fault, but are signs of a nervous center growing old, and the faintness, giddiness, and irregularity of the heart may be, not cause

ress in the wrong direction may occur, as the result of overstrain,—changing a moderate into a severe case. In general, it may be said that the patient does not often survive a well-marked degree of cardiac dilatation for more than from twelve to eighteen months.

The factors upon which we should lay weight in determining the reserve power of a dilated heart are of two kinds, rational and physical. If the disease has come on in one whose habits can be greatly changed for the better, with

regard either to overindulgence in alcohol, tobacco, the pleasures of the table, and such like, or sorrow, anxiety, overwork, and long hours of sustained effort, then the chances are somewhat more favorable than if the subject has led a physiologically blameless life. The judiciousness or unsuitableness of the treatment heretofore adopted should also be considered. And those who

obtain for the patient a fair degree of sleep and maintain a sufficient nutrition of the body.

It is oftener possible to produce a certain degree of improvement than to maintain it, to say nothing of completing the recovery.

A fatal termination may be preceded by attacks of syncope, often most alarming; but death is more apt to come at

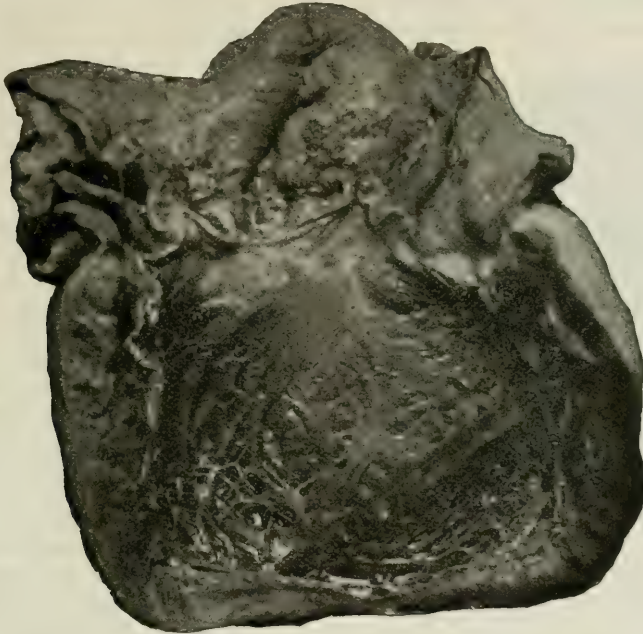


Fig. 4.—Left ventricle greatly dilated, but its walls of normal thickness. Aorta extremely atheromatous and enlarged. Man aged 44. Cardiac symptoms of pain, dyspnea, and palpitation for ten years. Death in a seizure.

have previously undergone one or two attacks of cardiac failure are to be regarded in a more dangerous condition than during their previous illnesses.

Irregularity in the pulse is not necessarily of evil import, but a great frequency of the pulse rate is discouraging. Of course, any degree of vigor in the cardiac impulse is a welcome discovery, as is also a sharp and decided quality in the second sounds at the base of the heart. The case may be considerably affected in its course by our ability to

the end of a comatose condition than with extreme suddenness. Embolism and thrombosis may also prove terminal factors.

TREATMENT.—Absolute rest in bed is very desirable if the patient is able to enjoy it. In many cases, however, the sufferer cannot assume the horizontal position, but is obliged to sit either propped up in bed or in a chair where he may bend his knees. For such unfortunates sleep is often best obtained by providing them with a shelf or rest

in front of them at about the level of the elbows, on which they may lean, bending forward. There are special tables made with a leaf reaching over the bed.

The **diet** is of great importance. It should be bland, easily digested, and given in small amounts at intervals of two or three hours. The total intake of fluids should be limited to 1500 or even 1000 c.c. (1 quart) in the twenty-four hours. Some cases



Fig. 5.—Dilated left ventricle, showing trabeculae flattened and indistinct. Mitral valves extensively destroyed and covered with large vegetations.

have seemed to do well on a strict **milk diet**, particularly such as have suffered from high arterial tension. In most, however, a variety of rather concentrated, but simple viands is preferable. Thus we may allow eggs, fowl, underdone beef or mutton, beef-juice, buttermilk, and gruels made with one-half milk and one-half water. Alcohol as a beverage or long-continued tonic is useless and harmful. It should be reserved for emergencies, unless, indeed, the patient has become so accustomed to it that a small amount of whisky or dry wine is almost necessary

to stimulate the appetite and digestion. It is the view of some that habitual alcoholic stimulation is more desirable in old age than in earlier life; but the writer's experience has satisfied him that, in the condition under consideration, great caution should always be used in regulating the administration of alcohol.

In mild cases of cardiac debility and cardiac dilatation, with little or no dilatation, regulation of **rest** and **diet**, as well as attention to digestion and elimination, will suffice to bring about recovery. Even in such instances some cardiac tonic is helpful as a means of accelerating improvement. Small doses of **digitalis** are the most useful. If it does not cause gastric or enteric irritation the tincture is best and the dose should not exceed 5 minims (0.3 c.c.) twice a day. The remedy may be combined with **nux vomica**, if it seems advisable to do so. In graver cases absolute rest and general **massage**, with careful diet and free elimination, must be employed, as well as larger doses of **digitalis** and **strophanthus**. If the arterial pressure is high, the **nitrites** are indicated, and if the liver is enlarged, **mercury** with **digitalis**; if the renal secretion is scanty the addition of **citrate of caffeine** and of **citrate of potassium** will be helpful. G. A. Gibson (Lancet, May 4, 1912).

Constipation and flatulence interfere with abdominal respiration and impede the venous circulation. Laxatives are consequently of great value, and more especially hydragogue cathartics. Enlargement of the liver increases the advisability of their employment. In suitable cases the relief from a purge is almost magical. It seems to produce the same mechanical effect that venesection would without the loss of strength which the latter measure involves. The favorite drug is **mercury**, either in the form of **blue mass** or the **mild chloride**.

This may be followed the next morning by a dose of **sulphate of magnesium or sodium** in concentrated solution. The advantage of mercury over other cathartics is that it not only depletes the veins, but dilates the capillaries, and thus lessens the obstruction which the weakened heart has to overcome. Another efficient and not very unpleasant remedy for the same purpose is composed of equal parts of **bitartrate of potassium and compound jalap powder**, of which the dose is 1 or 2 teaspoonfuls. By far the best cardiac stimulant in this condition is **digitalis**. It should be given in efficient doses. If the desired effect is not obtained with ordinary amounts, the remedy should be gradually pressed until either there is improvement or nausea interferes with its further administration. In some cases it may be given by means of an enema, subcutaneously, or intravenously, when the stomach altogether rejects it. Its well-known cumulative action should be remembered, and it should not be longer continued if nausea begins or the amount of urine diminishes. In fact, practically, one must be ready to suspend it about as soon as it produces a marked satisfactory effect (see **DIGITALIS**). As substitutes for digitalis, tincture of **strophanthus**, **caffeine**, and **sulphate of sparteine** may be employed, their probable efficacy being in the order named.

The first and most important treatment of cardiac dilatation is complete physical **rest**, accompanied by proper attention to **diet**, and nervous influences. Next to that is **digitalis** or the corresponding physical effect found in the **Nauheim treatment**, and, during convalescence, **graduated exercises**. L. Faugères Bishop (Med. Era, March, 1910).

The preparations of **iron** are useful for their beneficial effect upon the nutrition of the heart-wall. **Quinine** and **arsenic** are advised in certain cases. It is hardly safe to give the latter to subjects in whom fatty degeneration is suspected. On the other hand, arsenic sometimes appears particularly efficient in cases where there is cardiac pain.

Massage may do good in two ways, both by promoting general nutrition and by assisting in the propulsion of the blood. The **Schott method** of treatment may be of advantage in less alarming cases where there yet remains some muscular integrity in the heart. **Oertel's method** of treatment is suitable in so far as the amount of liquid ingested may often be limited to advantage, but unsuitable with regard to the forced muscular effort he advised. Climbing is more useful for obesity with fatty overgrowth of the heart than for conditions of cardiac dilatation. Accumulations of fluid in the abdominal or thoracic cavities should be withdrawn. It is sometimes surprising how much benefit will follow the removal of 12 or 16 ounces of water from the chest or a few quarts from the abdomen, *i.e.*, **paracentesis**.

In well-marked cyanosis with considerable enlargement of the liver half a dozen **leeches** may give relief. They may be applied directly over the liver, and the subsequent bleeding should be encouraged by **warm, wet compresses**.

The legs in some instances are immensely distended with fluid. Bullæ are apt to form, which burst spontaneously and exude dropsical fluid. Large amounts of water may sometimes be drawn from the lower extremities through **Southey's capillary trocars** or by means of **longitudinal scarifications**. A practical objection to the

latter method is the great danger of erysipelas attacking the scarified tissues. Apart from that, the constant dripping day and night torments the patient and soon causes more or less eczema of the skin. But the relief to the circulation is, in some instances, worth even the immense amount of trouble and the considerable risk thus entailed.

For the attacks of syncope to which these patients are liable, the subcutaneous injection of **digitalis**, **ether**, **alcohol**, **camphor**, **caffeine**, or **strychnine** is necessary. Recently the glucosid **strophanthin** has been employed intravenously in doses of $\frac{1}{240}$ to $\frac{1}{60}$ grain (0.00027 to 0.001 Gm.). It cannot be given safely if digitalis has been administered, nor repeated within twelve hours. Sometimes its efficiency is marvelous. Marked relief and apparently valuable stimulation are sometimes obtained by the **inhalation of oxygen gas**, which has once or twice seemed to the writer actually life-saving in its efficacy. In such cases, however, a fatal termination is merely delayed, not absolutely prevented.

The main indications for treatment are first to increase the power of the heart's walls, and, secondly, to relieve the venous engorgement which has arisen from their loss of function. The more pressing duty is to unload the venous system. It is seldom that a general **venesection** from the arm can be justified, unless it be of small amount, not more than 6 or 8 ounces. Direct **bleeding** is oftener better done by the application of 6 or 8 leeches to the epigastric or hepatic regions. **Leeching** affords more relief and comfort than the amount of depletion would indicate. A poultice should be placed over the leech-bites, which encourages further depletion and induces a

favorable hyperemia over a large surface. The hepatic congestion should be further relieved by **purgation**, the best purgative being **mercury** in some form. It is the best agent for lowering the resistance in the arterioles and capillaries, and thus relieving the labor of the exhausted cardiac walls.

The **diet** is important. It should be rather dry if it can be borne. Small quantities of solid or semi-solid food, every three or four hours, are best. Much fluid with the meal is objectionable, as it depresses the stomach and the heart. Alcohol is commonly necessary, and is best given as old **brandy**, not more than 2 to 4 ounces (30 to 60 c.c.) in the twenty-four hours being given. **Hot water** should be given in the morning to promote diuresis; when the heart is once relieved, the urinary flow is more free. Ascites, if urgent, may demand **tapping**, and extreme edema of the legs must be dealt with by **Southey's trocar**. There is often difficulty in securing adequate **rest** and **sleep** at night. Recumbency is seldom possible, and the patient may be allowed to sit in a properly adapted chair with support for the arms and a rest arranged for the head to lean somewhat forward. Dyce Duckworth (Lancet, June 15, 1907).

Drugs should not be given for the purpose of slowing the heart in acute fever. The writer has during late years entirely discontinued the use of aconite and, to a large extent, that of digitalis and its group in cases of this kind, although when a *previously diseased* heart is known to exist it may be desirable from the first to give **digitalis** to get the necessary rein on the heart so that it may better respond to quick stimulation if necessary later on in the disease. The **ice-bag** to the **precordium** is invaluable in the acute fevers. When it is apparently accentuated by nervous stimulation, the writer gives **codeine**, the **bromides**, and **morphine**. **Venesection** is advisable in many in-

stances, especially in full-blooded patients. In the control of high temperature coal-tar products should not be used, although they often reduce the excessive temperature very promptly. They are all more or less toxic to the cardiac muscle, and are therefore more apt to add to the degeneration in these diseases than to lessen it through reduction of the fever. Again, **alcohol sponges, cold-water packs, ice-water enemata, spray baths**, and the like are the most safe measures.

For the prevention of dilatation in the fevers, every unnecessary strain on the circulatory apparatus should be removed. **Rest** in bed, with the interdiction of certain movements, such as sudden sitting up, or turning, is very necessary. Relief from mental excitement and stress and from any other factor which may cause a rise of the blood-pressure, especially a sudden one, or which may excite increased rapidity in the heart action, is very essential. Brooks (N. Y. Med. Jour., Sept. 9, 1911).

PERICARDIUM, DISEASES OF THE.

PERICARDITIS.

DEFINITION. — Pericarditis is characterized by inflammation of the pericardium, the result of primary or secondary infection.

SYMPTOMS.—The subjective symptoms may vary greatly in severity. In mild cases the disease may call no attention to itself, and its discovery can only be made, if at all, by means of careful physical examination.

In severer cases there is uneasiness or pain in the cardiac region, with moderate fever and a general feeling of bodily distress. An important symptom is shortness of breath. There may also be palpitation, tenderness in the precordial region, and a dry cough. As fluid accumulates in

the pericardial sac, the symptoms change correspondingly, the heart's action being more embarrassed (especially its diastole), the dyspnea and sense of anxiety increasing, yet pain, on the other hand, diminishing. In young children pain is usually absent. It has been stated that the pain is greater in pericarditis with effusion than in merely fibrinous pericarditis. This statement applies, so far as regards cases with effusion, to the time before the effusion develops.

The pain may be due to friction or be of cardiac origin. Cardiac pain is rare, and is met with only in acute cardiac dilatation. Friction is the most characteristic sign and, when present, is conclusive. Cardiac dullness is always increased. One of the earliest signs is said to be such increase toward the left base. The writer considers this due, not to effusion, but to dilatation of the left auricle. The difficulty of diagnosis, even by the most competent diagnosticians, between pericardial effusion and cardiac dilatation is proved by the experience of paracentesis. Systolic recession of the apex beat is pathognomonic of adherent pericardium when present, but the converse is not true. Effusion muffles the heart sounds, but they may be equally weak from dilatation only. A perverted pulse-respiration ratio is often as marked in acute pericarditis as in acute pneumonia. True pulsus paradoxus is very rare, except with mediastinopericarditis; however interesting, it is of no practical use in diagnosis. When the effusion is large, there may be bulging or prominence of the epigastric region, with pulsation that can be seen and felt; also displacement of the left lobe of the liver. S. West (Brit. Med. Jour., Oct. 26, 1907).

The writer observed an absence of abdominal respiratory movement in pericarditis in the absence of more obvious thoracic and abdominal le-

sions. In 4 cases the pericarditis was associated with chorea in children. In 2 there was to-and-fro friction or cantering rhythm with loss of abdominal movement. Another, admitted with rheumatism and mitral regurgitation, developed chorea, and at the same time loss of abdominal movement was noted and pericarditis recognized by well-marked friction at the base of the heart. W. E. Wynter (*Med. Press and Circular*, July 2, 1913).

The pulse at first is apt to be rather forcible; in later stages it becomes irregular, intermittent, and of low tension. The disturbance of cerebral circulation is shown by wakefulness, headache, and in severer cases dullness, delirium, or even melancholia. Rare complications are chorea and epilepsy.

Great distention of the pericardial sac may occasion dysphagia, which may be lessened if the patient is raised into a sitting posture or bends forward. Sometimes the difficulty in swallowing appears to be due merely to nervous disturbance. There may likewise be vomiting, of nervous origin, because of irritation of the recurrent laryngeal nerve. Balfour warns us that the occurrence of delirium in the course of rheumatic fever ought at once to direct attention to the heart.

As regards objective symptoms, the disease may, as already said, run its course without directing the patient's attention to its existence; likewise the disease may escape the persistent and assiduous efforts of the physician to discover it. In general appearance the patient is apt to be anxious, distressed, and have a dusky countenance.

Before any effusion has accumulated in the heart-sac there may be tenderness or friction over the cardiac

area; there is not apt to be great enlargement of the heart, although it may become somewhat dilated. In the early stages of the disease the heart's impulse is somewhat exaggerated, but later it becomes feeble. The veins of the neck may be distended or may even display pulsation. If there is considerable effusion, the precordia may be somewhat prominent, especially in children, and the intercostal spaces raised so as to be on a level with the general surface. Sometimes the affected region exhibits edema, particularly when there is pus.

On auscultation it may be possible to detect friction. The apex beat may be felt in its normal condition. As an effusion collects, the apex becomes less easily palpable, and finally disappears. Sometimes, however, it will be discovered if the patient can bend forward, thus causing the heart to approach again more closely to the chest wall.

Two cases of effusion in which the patients found the knee-elbow position the only comfortable attitude. Hirtz (*Nord Méd.*, June 1, 1911).

Gibson states that "the vocal fremitus over the sternal region loses some of its intensity, and even fluctuation has been observed." As fluid collects in the sac, the area of cardiac dullness increases in every direction. The classical description of the shape of the dull area is that it resembles a triangle, or a pear hanging by its stem, with its base at the lower part of the chest. These shapes are more often exhibited by large than by moderate effusions. The extension of the dullness upward and to the right is quite constant. It is possible that adhesions may modify the position of the fluid. Sears, for example, men-

tions a case in which the heart lay against the anterior chest wall, and about half a pint of pus had collected behind the organ.

There are four characteristic points about the enlarged area of dullness: (a) The apex beat, as determined either by palpation or auscultation, is found to lie an inch or two within the left border of dullness. (b) The cardiac impulse is feeble and difficult of appreciation, which would not be the case if the extensive dullness were due either to hypertrophy or dilatation of the heart itself. (c) The normal heart sounds are feeble and distant, while *perhaps* the radial pulse is comparatively strong. (d) The angle formed by the right border of cardiac dullness and the upper border of hepatic dullness is obtuse instead of acute.

A large collection of fluid may affect the pulse in a peculiar way, which, although not pathognomonic, is of considerable value. The "paradoxical" pulse, as it is called, varies with the cycle of respiration, becoming weaker or imperceptible during inspiration.

Pericardial effusion produces stenosis of the venæ cavæ, which stenosis is relatively compensated by a rise in venous pressure, but this compensation fails when the pericardial pressure is greater than the venous pressure. Owing to respiratory change in venous pressure the degree of broken compensation varies in inspiration and expiration—greatest in inspiration, least in expiration. The variation in compensation carries varying quantities of blood to right heart (and to general circulation), least in inspiration, greatest in expiration. The respiratory variation in quantity of blood passing to general circulation is sufficient to explain *pulsus paradoxus*. Calvert

(Jour. Amer. Med. Assoc., April 6, 1907).

The distinctive auscultatory sign of pericarditis is the friction sound. This may be heard over any part of the heart, more frequently, however, at the base than at the apex. It is near the ear, increased by gentle pressure with the stethoscope, and is described in various cases as rubbing, grating, or creaking; it is apt to be somewhat harsh and it may be interrupted, or "jerky." It may be systolic or diastolic in time, more often it is a double murmur, and it may be triple. In any case it is not apt to be exactly synchronous with the systole and diastole of the heart. In this respect, as well as in its nearness to the ear, it differs from the endocarditic murmurs, and it also differs in the limited area over which it may be heard.

Josserand, some years ago, called attention to a sudden and violent clanging diastolic sound in the pulmonary area as an early sign. In 2 recent cases the writer noticed the development of this sound and it was soon followed by other signs of pericarditis. The peculiar clanging nature of the secondary pulmonary sound was very pronounced and the vibration could be perceived by the hand. The second aortic sound was perceptible but less marked. Turrentini (Revue méd. de la Suisse Romande, March, 1913).

The pericarditic friction is not transmitted so far as are valvular murmurs. Friction may not be heard when the patient is lying horizontally, and becomes audible when he sits or bends forward. Sometimes it is heard inside the angle of the left scapula. The intensity of the friction is influenced by respiration, being usually louder during inspiration.

The heart sounds proper are feeble and distant, or they may be drowned by the friction murmur. Cases which present both endocardial and pericardial murmurs are naturally perplexing.

Certain accessory signs in the lung remain to be mentioned. In the case of large effusions the percussion sound in the left axilla at about the level of the nipples is a muffled tympany; posteriorly below the angle of the left scapula the compressed lung may give a slight dullness on percussion and bronchial breathing.

Dullness and bronchial breathing over a portion of the left back, near and below the angle of the scapula, are often said to accompany pericardial effusion, and emphasis is laid on the presence of a considerable amount of fluid in the pericardium; but such signs are often encountered in cases of acute fibrinous pericarditis with to and fro friction and little evidence of effusion. Of 53 patients with acute pericarditis and friction rubs, observed by the author, 39, or 73.5 per cent., showed abnormal signs in the left lower chest behind. In none of these cases was there evidence of any considerable amount of fluid in the pericardium, a fact confirmed in many by aspiration or at necropsy. The signs found included dullness of varying extent, bronchial breathing, and bronchophony. Conclusion is reached that these physical signs were probably due to compression atelectasis of a portion of the left lower lobe. This compression seemed to be due to the heart and pericardium, to some pleural exudate, or to both. It was also possible that there might have been some intrapulmonary inflammatory changes, but this was not proved. The pulmonary signs did not seem to be of any significance with reference to the course or the prognosis of the pericarditis. H. A. Christian (Jour. Amer. Med. Assoc., Aug. 10, 1918).

The rapidity of the process varies greatly. Sometimes a dry pericarditis lasts but few days; a rheumatic pericarditis may cause a rapid effusion of serofibrin, so that in forty-eight hours the sac will be much distended, and in other instances there is a gradual increase of fluid for several weeks.

Children with "dry" pericarditis often lie on their faces to gain relief from pain. Miller ("Med. Dis. of Children," p. 375, 1911).

Rheumatic cases usually pursue a favorable course, and seldom demand active interference. On the other hand, when the pericarditis complicates pleurisy, pneumonia, valvular disease of the heart, or chronic nephritis, life is in great danger.

In the 100 cases of rheumatic pericarditis friction sounds were noted in 50 per cent.; in 14 there was a slight effusion besides the friction and in 35 per cent. the effusion was moderate to excessive. In pericarditis of other origin there were friction sounds or no symptoms in about two-thirds and an effusion was evident in less than one-third. In 47 cases with very much effusion the symptoms did not compel intervention in 16, but puncture was required in 25. In some of the cases the pericarditis was the first sign of the rheumatic infection and typhoid was suspected at first. Zinn (*Therapie der Gegenwart*, Sept., 1909).

In the diagnosis of pericardial effusion a fact of importance is that bulky pericardial effusion almost never occurs in rheumatic carditis, and that most of the signs hitherto supposed to indicate the presence of such an effusion are in reality due to dilatation of the heart, the consequence of the myocardial changes which are invariably present in acute rheumatic carditis. This latter statement applies with special force to the "pear-shaped" dullness which has been regarded as a sign of effusion.

This change from the normal area is due to extension of dullness in three directions: upward and to the left, to the right in the fourth and fifth right interspaces, and to the left at the left base. Comparison of clinical and pathological data proves that these three expansions of the cardiac dullness are due not to intrapericardial exudation, but to dilatation of the left auricle, the right auricle, and the left ventricle, respectively. Again, the cardiac sounds may, and often do, become indistinct in carditis as a direct result of muscular enfeeblement. It is no use to depend on disappearance of friction sounds, as even in the presence of a large effusion a rub may still be heard at the base. Discussion at Royal Soc. of Med. (Proceedings Roy. Soc. of Med., iii, Med. Sect., pp. 55, 77, 1909-10).

In septic cases pus develops rapidly; death may ensue in three or four days.

Acute pericarditis is a secondary infection, with extension from adjacent structures uncommon, but the vast majority of infections are probably via the blood stream. Pain in the precordial area is not as common as is supposed. A good many mild cases pass unnoticed because there is neither pain nor distress. Pain is so much more common in pleuritis, and pneumonia plays such a factor in pericarditis, that it is often difficult to separate the two. The difficulty of diagnosis is illustrated by the fact that acute pericarditis was recognized clinically only 100 times in 34,467 cases and 12 times in 78 autopsies at the Boston City Hospital. Pneumonia is the chief agent in the production of purulent and of fatal pericarditis. *Pneumococcus pericarditis* or *myocarditis*, or both, should be considered, especially in young or middle-aged adults, when the heart shows failure of compensation before the crisis or after it when there is fever or delayed convalescence. The prognosis of acute pericarditis following acute arthritis is generally

favorable to life. *Pneumococcus pericarditis* is grave at any stage. Tuberculous pericarditis is not common, and is usually a late involvement in an advanced case. Robey (Amer. Jour. Med. Sci., Apr., 1917).

Tuberculous pericarditis is almost absolutely hopeless, although it may pursue a chronic course.

The writers observed a case of tuberculous pericarditis with much effusion in which the diagnosis was long dubious; pericardiotomy alone cleared up the case and has apparently cured the patient. This affection has no pathognomonic signs or symptoms; even puncture may prove misleading and do actual harm, while from the therapeutic point of view it is inadequate and has to be inevitably followed by pericardiotomy sooner or later. They advocate therefore **pericardiotomy** as the routine procedure. O. Jacob and Chavigny (*Revue de méd.*, July, 1911).

In a personal case of bacillary pericarditis the tuberculous nature of the pericarditis was recognized only by aid of the microscope, so that such a condition is evidently readily overlooked. Simmonds (1898) stated that the condition of isolated pericardial tuberculosis is not so rare, while in 1904 Askanazy held that a purely idiopathic case is decidedly rare. Other pathologists are in agreement with Simmonds. There is undoubtedly a true isolated bacillary disease of the pericardium in which we do not find any of the histological components—neither tubercles, giant cells, nor caseation. The human tubercle bacillus simply determines an ordinary pericarditis—acts non-specifically. Fromberg (*Deut. med. Woch.*, Aug. 7, 1913).

DIAGNOSIS.—From what has already been said it follows that in some instances pericarditis cannot be diagnosed, subjective and objective symptoms both failing. Other cases are self-evident. In a third class of

cases we have the possibility of confusion with endocarditis; hypertrophy, or dilatation of the heart; myocarditis, and localized pleurisy.

The endocarditic murmurs are apt to be localized at places corresponding with the valves of the heart, and to be transmitted farther than friction sounds. They are, moreover, synchronous with the heart's movements, and they usually have a softer, blowing, and distant character, which contrasts with the harsher sound, near the ear, of pericarditis.

It is often difficult or impossible to differentiate an extremely dilated heart from a large pericardial effusion. The following may assist in doing so: Whereas in cases of enlarged heart the sternum is depressed, the right lobe of the liver elevated with reference to the overlying interspaces, and the right lung elevated as well as pushed outward and backward, thus giving a high position of the liver associated with a narrow band of lung-liver relative dullness, in pericarditis with effusion, on the contrary, the liver is depressed and the right lung pushed outward and backward, more than it is upward, thus giving a low position of the liver with the same narrow band of lung-liver relative dullness. The size of the liver itself is of no material importance in this connection. W. J. Calvert (Trans. Amer. Med. Assoc., June 7, 1910).

The hypertrophied heart is usually easily distinguished from pericarditis; the impulse is vigorous, the heart sounds loud, and the outline of dullness is, although greater than in health, yet approximately normal in shape.

Certain cases of dilatation of the heart are perplexing, especially where the pericardial friction sound has been heard within a short time previous.

The observer is obliged to consider carefully whether the enlargement of the cardiac area of dullness and the feebleness of the heart sounds are due to change in the heart wall or to an effusion outside of it.

In dilatation the heart sounds are clear, and the first sound of the heart may be, although valvular, quite strikingly distinct. The apex of the heart is never displaced upward by mere dilatation.

The cardiac impulse is often extensive in cases of dilatation, although giving the impression of feebleness and irritability, and the area of dullness is rather more quadrilateral than pyramidal, although, it must be confessed, too much reliance should not be placed on this distinction.

A rough systolic murmur simulating that of pericarditis may be heard at the base in case of chlorosis, but usually the two diseases can be distinguished without difficulty.

Considerable stress in point of diagnosis has been laid upon the fact that pericardial murmurs become more distinct when the patient sits up in bed, but it should be borne in mind that similar changes are not infrequently demonstrable in the case of endocardial murmurs.

Diagnosis is difficult in those cases in which a friction murmur has never been detected. If, however, the patient's condition becomes threatening, and the possibility of a considerable effusion exists, it is a proper and comparatively safe measure to insert an hypodermic needle, with aseptic precautions, so as to see whether fluid can be obtained. Perhaps the best point to choose for this purpose is the fifth left intercostal space, an inch and a half from the edge of the sternum. Shattuck, and also

Strümpell, recommend the lower left part of the pericardial sac, a little way inward from the margin of dullness. Another place is the left costoxiphoid angle: a spot which is probably perfectly safe when there is a large effusion, but otherwise renders one liable to perforation of the liver and diaphragm. If a sharp-pointed needle is employed suction may be begun as soon as the point of the needle is engaged in the tissues, and the needle then pushed cautiously forward until fluid begins to run.

A disadvantage of the needle is that its point may scratch the surface of the heart as it moves in systole and diastole. The trocar and cannula are not open to this objection, and are, on the whole, preferable. Moreover, a cannula can be moved about in order to loosen any adhesions. If there is strong reason to feel that fluid has collected, more than one effort to find it should be made.

While it is important to avoid puncture of the heart itself, this has occurred repeatedly without special damage, and in only one recorded case has such an accident proved fatal. Sloan saved a moribund patient suffering from pericarditis by unexpectedly drawing 10 ounces of blood from the right ventricle.

It must have fallen to the lot of most who have had a large experience of pericarditis to have operated on cases in which effusion had been diagnosed, and to have instead a greatly dilated heart, with or without an adherent pericardium, but no effusion. The difficulty of diagnosing between these two conditions is often very considerable. An extreme degree of cardiac dilatation is commonly met with in rheumatic pericarditis, more especially in children, and is frequently associated with

general adhesion of the pericardium to the heart; whereas effusion to any great extent is comparatively rare, mistakes in diagnosis based on rapid increase of area of the cardiac dullness are less liable to be made. The writer has failed to find the shape of the area of cardiac dullness, *e.g.*, the so-called "pear shape" described by Sibson, of any value in determining the presence of effusion. Rotch's sign is certainly not to be relied on as diagnostic of effusion; in many instances the writer found it present in cases of universally adherent pericardium in children, especially in the relapsing cases in which the dilatation of the heart is often extreme. Sir John Broadbent (*Lancet*, March 12, 1910).

Where the facilities are available, röntgenoscopy may be resorted to with advantage.

The effusion must be of considerable volume to be evident on röntgenoscopy; the curve of the heart outline is changed from normal, the shadow assuming more a triangular shape and the pulsation of the heart becoming less evident. The pulsation of the lower margin of the heart is transmitted to the air-bubble in the stomach in normal conditions, but when there is an intervening accumulation of fluid in the pericardium only a minimal pulsation is transmitted from the right ventricle. The findings are more pronounced if the air-bubble is rendered conspicuous by taking an effervescent powder. V. Maragliano (*Riforma Medica*, Oct. 19, 1912).

ETIOLOGY.—Pericarditis is never an idiopathic affection. It may be due to infectious germs, or to toxic conditions of the blood, or to inflammation extending from contiguous organs. It is very frequently associated with acute articular rheumatism, and it may precede the joint symptoms, especially in children. It may also complicate scarlet

fever, measles, small-pox, and typhoid fever.

It sometimes occurs in diphtheria, and not so very seldom in association with pneumonia. Septic processes may give rise to it, such as acute osteomyelitis, puerperal fever, and gonorrheal infection. It has been known to occur after tonsillitis. Tuberculosis is a very important cause.

Case of postinfluenzal pericarditis in a man aged 21 years who was seized on March 4th with giddiness, nausea, and aching in his legs; this was followed on the next day by a very slight nocturnal cough and pain over the precordial area, chiefly limited to the apex beat. The temperature was normal; the pulse was 85 per minute and of good volume and tension. The writer diagnosed influenza. Examination of the chest revealed nothing abnormal until on March 13th the chest was again examined. Inspection, palpation, and percussion yielded no evidence of disease, but on auscultation over the space between the second and third rib, close to the sternum, a double friction sound was to be heard. It was nearly synchronous with systole and diastole, the heart sounds were partly obscured, but no murmur nor reduplication was present. When the patient held his breath the abnormal sounds were not altered. The area over which the friction sounds could be heard was of about the size of half a crown. They were very high pitched and sibilant and were greatly increased on pressure on the chest with the stethoscope. On the next day they were not so well marked and the day after that were quite gone. The patient says that he had an attack just like the present one last year and a medical man said "it was influenza affecting the heart."

It is curious that the pericardium should be affected by so mild an attack of influenza, especially with so few bronchial symptoms. It seems

to prove that Pfeiffer's bacillus circulates in the blood early in the disease in even a mild form and produces a true septicemia. F. C. Doble (Lancet, April 4, 1908).

Its occasional development in cases of chorea brings to mind the mysterious association between rheumatism, chorea, and pericardial disease. Another important cause is chronic nephritis. Gout, scurvy, purpura hemorrhagica, leukemia, and cancer also deserve mention.

Pericarditis has long been recognized as a complication of chronic nephritis. Bright believed its frequency due to chemical alteration of the blood. The writers have studied 11 cases, 7 recognized during life. All showed high nitrogen content of the blood-serum, 5 cases having between 1.87 Gm. and 1.95 Gm. per liter, 6 2.3 Gm., and 3 over 3 Gm. In 4 cases cultures from the pericardium showed no growth; 2 cases showed *Bacillus coli*, which did not, however, agglutinate the patient's serum collected *ante mortem*; 1 showed streptococcus, and 4 pneumococcus, 2 of which had concomitant pneumonia. Pericarditis in Bright's disease is thus a manifestation of marked nitrogen retention. F. Widal and A. Weill (Jour. Urologie, i, 177, 1912).

The disease attacks youth and middle life oftener than old age. Addiction to liquor increases the liability to pericarditis. Males are somewhat oftener attacked than females.

By extension from contiguous organs the disease is developed in pleurisy and pleuropneumonia, endocarditis, purulent myocarditis, aneurism of the aorta, and also from disease in the bronchial glands, the bones, the esophagus, and even the abdominal viscera (Osler).

PATHOLOGY.—The changes in the pericardium due to inflammation correspond closely to those seen in

other serous membranes, particularly the pleura. The first change is an injection of the superficial blood-vessels, which may give the whole surface a dull-red color. Fibrinous exudation may consist either of a few stringy deposits, or a more uniform thin membrane, or, again, a thick, irregular coating. This coating may be ridgy, honey-combed, or shaggy. In chronic cases it may become of enormous thickness, and even present plates of cretaceous material.

In a careful study of the autopsy reports of the Boston City Hospital for 19 years, acute pericarditis was found in 4 per cent. of all autopsies. In this series of autopsies acute endocarditis was described in 5 per cent. and chronic endocarditis in 12.6 per cent. In only 27 instances among the 150 cases of acute pericarditis was there any clear evidence in the clinical notes of the presence of diseased state of the pericardium. The most glaring errors are in the cases of pericarditis with effusion of various forms. The writer believes that in at least 50 per cent. of these cases it should be possible to diagnose this condition with reasonable certainty. Rheumatism is the commonest cause, and in adults pneumonia and pleurisy probably comes next. A less common cause is tuberculosis of the thoracic organs or acute miliary tuberculosis. The clinical picture is difficult to give. In not a few instances the onset is more or less well marked. The patient becomes restless, breathes with a shallow, rapid respiration, looks distressed and anxious, the face has a dusky pallor, and the patient complains of pain or oppression in the region of the precordia. Later symptoms depend largely on the degree of cardiac embarrassment and pressure from the distended pericardial sac. In the early stage the first and most important sign is the friction fremitus. As a rule this is double, though fairly

commonly it occurs as a single sound, or rarely triple. The pericardial sounds never begin or end with a shock, are of even intensity, and are heard most commonly at the base and over the middle portion of the heart. E. A. Locke (Boston Med. and Surg. Jour., Oct. 26, 1916).

In cases of serofibrinous exudation the amount of fluid varies between 200 or 300 c.c. and 2 liters. There is a record of the enormous quantity of 1 gallon. The fluid may be tinged with blood, especially in tuberculosis, cancer, and nephritis. Aged patients are apt to have sanguinolent fluid. Purulent exudations consist of a creamy or a thinner seropus; in some cases they are offensive: "ichorous."

In pneumococcal pericarditis, even when lobar pneumonia and pericardial infection coexist, the anatomical position of the pulmonary lesion is, in a majority of cases, remote from the pericardium; so that it is most likely that the pneumococci reach the pericardial sac through the blood-stream in the same way that they invade joints and other tissues (probably including the lung itself). Chatard (Johns Hopkins Hosp. Reports, vol. xv, p. 155, 1910).

In cases of rather long duration or great severity the myocardium is involved in the process to the depth of 2 or 3 mm., entailing an organic weakness which gravely affects the prognosis.

In case the patient survives the disease, permanent changes in the membrane remain behind. There may be small patches of cicatricial change, or a limited number of adhesions, or, again, the pericardial sac may be entirely obliterated, presenting the condition of chronic adhesive pericarditis.

The changes thus far enumerated relate to the inner surface of the pericardium; not infrequently the inflammatory process involves its outer

surface as well, giving rise to pleuro-pericarditis and mediastinitis, and eventually binding the heart in an unnatural degree to surrounding parts. (See below: CHRONIC ADHESIVE PERICARDITIS.)

Pick's syndrome consists of enlargement of the liver with obstinately recurring ascites, but without jaundice and without signs of cardiac abnormality, in a patient who gives a previous history of pericarditis. The latent pericarditis disturbs the circulation, thereby producing hepatic engorgement and also connective-tissue hyperplasia, which interferes with the ramifications of the portal vein and thus brings about the ascites. He calls it "pericarditic pseudocirrhosis of the liver." Corn-wall (N. Y. Med. Jour., May 20, 1911).

PROGNOSIS.—Acute fibrinous pericarditis is seldom fatal, and most cases of rheumatic origin recover. On the other hand, the disease is very often a terminal phenomenon in patients very ill with certain diseases, such as nephritis, pleuropneumonia, and sepsis.

Tuberculous pericarditis is almost invariably fatal. The rapid outpouring of a large amount of fluid is dangerous from its mechanical effect, and aspiration may then save life if promptly performed. Cases seemingly desperate may recover, even without intervention.

TREATMENT.—Pericarditis is not at all a disease in which routine measures are demanded or justified. Some cases, both of the fibrinous and sero-fibrinous variety, may progress to recovery unaided. If there is precordial pain or troublesome palpitation, **dry cold** may be employed **over the heart**; it should be used at first tentatively. We may employ an **ice-bag** covered with flannel, or **Leiter's coil**.

Pain may demand an **opiate**. A fair

amount of sleep for the patient is imperative. For this purpose **bromide of sodium** is useful and **paraldehyde** seems especially suitable, because it is somewhat stimulating. Robust patients in an abrupt and stormy onset of the disease may be benefited by **leeches** applied over the heart; but venesection and such cardiac sedatives as aconite are to be avoided.

The writer has used **opium** largely in heart affections, and has never seen anything but good follow its judicious administration. In acute pericarditis it is an invaluable remedy, for it allays the irritable, excited action of the heart in a way no other drug does. No large amount is required. Small doses at frequent intervals, say 5 minims (0.3 c.c.) of **laudanum** or so every four hours, are all that is necessary. Then the patient, who has been restless, distressed, and in pain, becomes quiet and relieved, the pulse rate drops 20 beats or more, and the action of the heart becomes steadier and more sustained. Many cases of rheumatic heart affections in the acute stage do better with opium than any other drug, and some seem to do no good without it. Samuel West (Brit. Med. Jour., Oct. 26, 1907).

Some patients obtain more relief from **hot** than from cold applications. Blisters are today little used, although some authorities believe that they hasten the absorption of effusion. Cantharides is contraindicated in nephritic cases. No internal remedies seem to have any specific effect either in preventing or curing the inflammation. However, in the rheumatic cases, the **salicylates** in full doses should certainly be tried.

Salicylates rarely prove effectual in rheumatic pericarditis, but they should always be given a trial. Pericarditis may occur in an encapsulated form; there may even be multiple encapsulated foci; some serous, others

with purulent contents. Absolute **rest** should be continued until the last trace of effusion and of friction sounds has vanished and the heart action is entirely normal. For local disturbances the writer applies cold in the form of an **ice-bag** suspended **over the heart**, or heat from **hot compresses**; the latter aid in relieving pain, while they have an unmistakable curative action and strengthen the heart. **Dry cupping** may also prove useful; **morphine** should be given without hesitation in case of excessive pain and restlessness. N. Ortnier (Deut. med. Woch., May 19, 1910).

If, as is likely to happen in the progress of the disease, the pulse becomes irregular, intermittent, and of low tension, resort must be had to **digitalis**.

The bowels should be kept open by **salines**, and **acetate of potassium** may be employed as a diuretic. Moderate amounts of easily digested nourishment should be given at brief intervals.

It has been stated that rheumatic cases almost always recover; this is true even when large effusions are developed, so that some delay in **paracentesis** is justifiable here; but in general it is better to be prompt in the removal of any large effusion. One purpose of this is to relieve the heart of mechanical embarrassment, and another is to discover the character of the effusion, for purulent pericarditis has a better chance of recovery if permanent drainage is early established. For other particulars with regard to aspiration see **DIAGNOSIS**.

Several surgeons have made independent studies of the best method for draining the pericardial sac. In a general way it may be said that an important point is to avoid opening the pleural cavity, which might cause pneumothorax or empyema.

The heart's action may be kept regular by local application of a 10 per cent. solution of **cocaine** during operations involving the pericardium. This opinion is based on experiences with dogs, the pericardium showing itself extremely sensitive to the slightest touch, while under the influence of cocaine the heart rhythm persisted regular throughout. Heitler (Med. Klinik, June 19, 1910).

The fourth (**Porter**), fourth and fifth (**Roberts**), or fifth and sixth (**Delorme**) costal cartilages near the sternum may be resected, the pleura and the internal mammary artery being drawn toward the left, and the pericardium thus exposed. As already mentioned in abstract form in the article on **CHEST, INJURIES AND SURGICAL DISEASES OF THE**, section on **PERICARDITIS**, Venus found that, out of a total of 300 reported cases of pericarditis in which the operative treatment had been resorted to in 197 instances, 72, or 40.45 per cent., were cured and 6, or 3.37 per cent., were improved. Venus holds that **puncture** is allowable only when there is no suppuration, which can be determined by an exploratory puncture. In case of suppuration, **resection of ribs** and **pericardiotomy** only can be considered. After pericardiotomy the pericardial cavity should be carefully rinsed with salt solution and extensively drained. In case of chronic adhesive mediastinopericarditis **Brauer's technique of cardiolysis**—osteoplastic resection of the wall of the thorax to release the adherent pericardium—has proved a life-saving operation and is evidently destined to play a prominent part in the treatment of this affection. The signs of failing compensation subside, diuresis is increased, the albumin vanishes from the urine, while the ascites grows less and the liver and

spleen become smaller. Patients who were incapacitated and bedridden were restored to comparative health and could resume their occupations. In the 17 cases in which cardiolysis had been performed up to the time Venus's article was published the effect was invariably favorable. A complete cure cannot, of course, be expected, from the nature of the affection, but by relieving the heart the general health is notably benefited.

Puncture should be made in the area of dullness to which West has attributed so much diagnostic importance—that which lies to the left of the point of maximum impulse—with Curschmann's flat trocar and cannula directed toward the apex beat. If fluid be found, its withdrawal should be effected gradually by siphon action. Ortner (Deut. med. Woch., May 19, 1910).

In an ordinary case, when the diagnosis is clear and there is choice of place given, the sites selected and advocated have been four: (1) In Sibson's notch—*i.e.*, in the third left intercostal space near the sternum—a dangerous place on account of the proximity of the left auricle. (2) In Rotch's angle, in the fifth right intercostal space, to the right of the sternum—another risky place, because the right auricle cannot be far away, even if the effusion be of large size. Sears, in a recent paper, says that he has tapped many times in this position, but generally without obtaining fluid. Schaposnikoff says the third or fourth space on the right side is better and safer than the fifth, but both are risky. The choice of Sibson's notch or Rotch's angle is based upon the experimental injections, which the author asserts are inconclusive. (3) The fifth space to the left of the sternum. This spot is advocated because the puncture is made in the spot which is not covered with lung, and so the pleura is not perforated. Though this may be a good place for trephining the

thorax with a view to incising the pericardium, it is not the best place for paracentesis. Nor need the risk of puncturing the pleura with the needle or with a fairly large trocar and cannula be seriously considered. In paracentesis the mere perforation of the pleura on the way to the pericardium does no harm. The writer states he has seen cases in which—where the needle inserted had perforated the pericardium, but the cannula could not be made to penetrate it—the fluid has leaked into the pleura, and been absorbed rapidly or subsequently removed from the pleura by tapping, in each case with rapid recovery of the pericardial effusion. (4) The safest place is the fifth or sixth intercostal space outside the left nipple line, but well within the area of dullness, for here, owing to the displacement of the heart upward and the distention of the pericardium outward, is the widest space between the heart and seat of puncture. This is the place the author advocates and chooses. All of the fluid that can be obtained should be removed. Often it does not reaccumulate, but if it should a second and third paracentesis may be performed, or as many as necessary. Cases are recorded in which the **paracentesis** has been performed many times. West (Lancet, Feb. 26, 1910).

A pericardial effusion requiring any surgical intervention at all ought to be treated by **resection of a rib** cartilage and free opening of the sac, just as one would open the dura mater to drain a cerebral abscess. It is the only safe and satisfactory method. The very presence of a large effusion makes the operation easier than it would be in a normal subject. Free opening should be the exploratory, and at the same time the curative, operation for all cases of large effusion, be the character of the effusion what it may. Boxwell (Dublin Jour. Med. Sci., Aug., 1912).

Three forms of intervention are in use: *First* is **puncture**, which is also

utilizable for diagnosis. Its surgical uses are in pericarditis with effusion, whenever the latter "tampons" the heart and cripples its action. The puncture is also made in effusion of blood into the sac. The operation is not to be undertaken except on the strictest indication on account of the danger of puncturing the heart itself. A puncture which is unwarranted usually results in a pericardiotomy. There is no typical puncture point, and many surgeons have their favorite localities. The fluid should be allowed to come away very deliberately, else the heart may collapse. The *second* method of intervention is **pericardiotomy** with resection of the ribs. This is preferred by some surgeons to puncture, but is employed by all for pus in the pericardium. This operation is of course borrowed directly from that in common use for empyema. There are many localities and methods for establishing the thoracic window. One is a simple trepanation of the sternum. The *third* resource, or **cardiolysis**, does not compete with the first two, and is meant solely to separate pericardial adhesions. The credit for planning and executing the operation belongs to Brauer. Some of the adhesions are external and it is naturally these which are most burdensome to the organ and are also accessible to surgery. The intervention is not one of great severity. A thoracotomy is performed and the adhesions detached. The number of cardiolyse performed thus far is small. Done as a strictly lifesaving procedure, it appears to have accomplished its purpose without injurious consequences. Kolb (Berl. klin. Woch., June 3 and 10, 1913).

CHRONIC ADHESIVE PERICARDITIS (EXTERNAL PERICARDITIS; PLEUROPERICARDITIS; MEDIASTINOPERICARDITIS).—The obliteration of the pericardial sac may not embarrass the heart's action in any important de-

gree. If, however, the adhesions are formed at a time when the heart is dilated, the heart cannot easily regain its normal size, and is apt to become incompetent. If the external surface of the pericardium, as well as the internal, forms unnatural adhesions, the condition is far more serious.

The writer found two types of pericardial adhesion in the course of a wide examination of autopsy records. One of these occurs in childhood. In this form the valves are also diseased and the heart hypertrophied, the whole group of changes being due to rheumatic invasion of all the cardiac tissues simultaneously. In such cases there are adhesions without and within the pericardial sac. Fenton (Practitioner, vol. lxxxix, p. 637, 1908).

In adhesions between the pericardium and the diaphragm, the functional disturbance is a set of symptoms suggesting angina pectoris. The physical symptom is the disappearance of the apex beat. The X-ray shows a shadow at the left side where the heart and diaphragm are soldered together. This triad characterizes adhesive phrenopericarditis. The writers have encountered 20 cases of this kind. Although the angina pectoris symptoms may be distressing at times, yet they never had serious consequences. Trémolières and Caussade (Presse méd., Apr. 4, 1918).

DIAGNOSIS.—In many instances internal adhesions are not capable of demonstration, although they may be suspected if there is rapid heart-failure after an attack of pericarditis. External adhesions may cause abnormal motions of the thoracic walls. Systolic retraction of the thorax in the neighborhood of the apex beat is particularly characteristic; there may also be an epigastric retraction, and one at the seventh and eighth ribs near the left edge of the sternum. It has also been stated that laterally and posteriorly

there may be a similar systolic depression at the base of the left chest. In some cases the *pulsus paradoxus* is produced, that is, the radial pulse becomes feebler or intermits with every inspiration.

Case of aortic incompetence, relative mitral incompetence, and complete pericardial adhesion. Pericardial friction sounds were heard for a few days, afterward subsiding. The patient was presented in the clinic as a case of fresh pericarditis, but autopsy a few days later showed old total obliteration of the pericardium with no recent inflammation. The adhesions were of long standing and the friction sounds must have been produced by the blood-clots rubbing against each other in the loose connective tissue of the pericardial adhesions. E. Richter (Berl. klin. Woch., April 27, 1908).

The presence of serious adhesions is to be inferred from a relative failure of recovery from acute cardiac rheumatism—that is, an abnormal severity and persistence of symptoms and signs after the patient has passed out of the years in which rheumatism is active. The inference of adhesion in such cases is materially strengthened if, at an earlier date, direct evidence of pericardial inflammation has been noted. Moore (Lancet, vol. ii, 1910).

The veins in the neck sometimes exhibit a diastolic collapse, being at other times overfull. Much value is placed upon the diastolic shock, or rebound, which may be felt on placing the hand over the heart's apex.

Other points are the wide extent of the cardiac dullness and of visible cardiac motion, and the fixity of the apex beat without regard to alteration of posture or respiratory influences.

None of the physical signs which have been described as diagnostic of adhesion is quite reliable; most of them are rather to be ascribed to the

permanent enlargement of the heart, which is an invariable accompaniment of widespread adhesion, but which may of course be present when there is little or no adhesion. Even Broadbent's sign (systolic recession of the left lower ribs behind) may be most definitely present in cases of cardiac enlargement which autopsy proves to be independent of pericardial disease, as in Paterson's case, and also in a scarcely less striking case observed by the writer. Carey Coombs (Bristol Medico-Chir. Jour., March, 1912).

The discovery of this condition is valuable mainly as a means of prognosis, the treatment being seldom satisfactory. The embarrassed heart may be stopped in a sudden fatal syncope, or go through the more gradual changes of broken compensation. Sometimes chronic mediastinitis extends through the diaphragm, in children, and gives rise to perihepatitis, perisplenitis, and chronic ascites.

Hitherto it did not make much difference whether chronic adhesive pericarditis was diagnosed, as treatment was merely medical and symptomatic. But now that surgical intervention has been proposed and cardiolysis performed in 18 cases, early differentiation is of great importance. Analysis of these 18 operated cases shows that the best results were obtained in the tuberculous variety with or without left pleurisy and mediastinitis. Preceding serous pleurisy was mentioned in 8 of the 15 cases reported in full. Rheumatism was known in the history of only 2 of the patients. As a rule, rheumatism attacks the entire heart, not the pericardium alone, and the rheumatic cases are not favorable for operative intervention. Only 2 of the patients failed to benefit by the cardiolysis, that is, the resection of ribs and breaking up of adhesions. Setting the heart free from its fusion with pleura or chest wall relieves it

of a large amount of excessive and unnecessary labor and conditions improve at once. Bulging of the precordium was noticed only in 1 of the cases; it is exceptional in adults. Pain in the precordium is an important and frequent sign; also the tugging retraction of the chest wall accompanying systole, and the diastolic rebound or shock. Both of the latter seem to persist after the operation. Increased area of dullness over the heart was noted in 7 out of 15 cases and jaundice in 2; ascites was a prominent symptom in 10 cases and a hard and enlarged liver in 11. The spleen was also enlarged in a few cases. In the child these latter findings exclude tuberculous peritonitis, while the absence of drinking habits in the adult speaks against the assumption of cirrhosis of the liver, which the syndrome otherwise suggests. Dropsical swelling of the legs was frequently observed, and occasionally cyanosis, for which no cause in the lungs could be discovered. Diastolic collapse of the jugular vein was another frequent symptom, but the *pulsus paradoxus* was only exceptionally encountered, although sought for in every instance. There is generally also habitual oliguria and considerable albuminuria, while traces of the primary pleurisy can usually be discovered. The age of the patients ranged from 8 to 50, but the best results of operative intervention were obtained in 10 patients between 15 and 30. Mouriquand (Jour. Amer. Med. Assoc., from Lyon Chir., Dec., 1909).

TREATMENT.—Injections of fibrolysin or iodolyisin may be tried. Thiosinamine has been recommended for dyspnea by Rénon in daily dose of 0.06 to 0.10 Gm. (1 to 1½ grains), either by injection or ingestion. It is contraindicated, however, in the tuberculous.

In some cases Brauers' operation of cardiolysis has given marked relief. The operation should be performed

during a quiescent period and not when an exacerbation of heart-failure is present. This renders the use of an anesthetic possible. The operation should not be done in the presence of a polyserositis. Marked improvement was obtained in 75 per cent. of the 38 cases referred to so far.

Cardiolysis, the removal of sections of the ribs which imprison the heart, in cases of extensive, adhesive medias-tinopericarditis, was first performed at the suggestion of Brauer, in 1902. The best time to operate is when the apex tug, and the diastolic shock, and Broadbent's sign are strikingly characteristic, because these symptoms indicate the struggle of a strong heart muscle. These signs fade as the tone of the heart muscle weakens; they are the indices for prompt operation. In order that a soft, movable, musculo-cutaneous covering of the heart may take the place of the bony chest wall, it is advisable in removing the ribs, that all their periosteal covering should go with them. The danger of collapse of the lung from accidental injury to the pleura in carrying out this technique is an imaginary one; the lung does not collapse. The pleural wounds are easily sutured after temporary occlusion with gauze sponges. The heart muscle in both cases reported by the author, was in an advanced degenerated condition, almost hopelessly so. Notwithstanding this, 1 patient, a man, lived 4 years and 10 months; was able during this period to earn his living, and was almost free from heart symptoms until the last several months of his life. The second patient lived nearly a year after operation following overstrain in attempting to do several women's work upon a ranch. Cardiolyisis is a valuable operation, as has been proved by the operations, 38 in all, which have been done abroad, chiefly in France, Germany and England. J. E. Summers (Surg., Gynec. and Obstet., xxv, p, 92, 1917).

As emphasized by Pitt, prophylactic treatment is most important. Much more might be done to prevent acute rheumatism from developing in children, by keeping the nasopharynx in a healthy condition and insisting that they should be instructed at school in nasal breathing. The majority of cases owe their origin to mouth breathing, and are very often associated with adenoids; but too often, when the adenoids have been removed, no instructions have been given about the training necessary to prevent their recurrence. Acute pericarditis is the most grave cardiac lesion of childhood. All patients with rheumatism should be put to bed as soon as possible and, if acute pericarditis develops, very prolonged rest in bed is necessary, when possible for at least six months, because if the heart's work is reduced to a minimum the heart is less likely to dilate, the adhesions will be less extensive, more supple, and more likely to be absorbed than when the child runs about and takes exercise.

HYDROPERICARDIUM. — In edema of the pericardial sac it is usual to find *post mortem* a teaspoonful or two of serous fluid in the pericardium, which probably transudes after death. Larger quantities may form during life as a result of chronic heart disease, emphysema, and more often chronic nephritis. In these cases there is no friction sound nor other evidence of inflammatory change. The symptoms are usually merely those of the causative condition, although, of course, a large amount of fluid may add to the embarrassment of the heart.

The prognosis and treatment are directed to the underlying disease, and it is rarely necessary to aspirate.

HEMOPERICARDIUM. — Blood in the pericardial sac is a rare condition which may be caused by aneurism of the aorta, aneurism of the coronary arteries, and by trauma.

Death occurs usually much too rapidly to permit any treatment, and diagnosis is rarely possible. In a few traumatic cases aspiration has been successfully carried out.

Case of a little girl who fell and drove half of a needle through her chest wall into the pericardial sac, with the production of an infected hemopericardium. This was aspirated twice with some relief, but it was deemed best to do an open operation. This was done over the base of the heart, removing the second, third, and fourth costal cartilages, and through the wound 300 c.c. of blood-stained fluid was allowed to escape. The point of the needle was to be felt projecting within the pericardium and it was removed from within. The wound was closed with a drain and so far as the surgical phase of the case was concerned all went favorably. Bronchopneumonia developed fourteen days after the operation and resulted fatally two weeks later. Gunson (*Lancet*, June 8, 1912).

PNEUMOPERICARDIUM. — Air in the pericardial sac may be caused by perforating glands, and by the perforation of some lesion in the lungs, esophagus, or stomach.

There is almost always a purulent exudation present in addition to the gas; rarely, there may be merely a serofibrinous fluid.

The auscultatory signs of such a condition are striking: the sounds take on a metallic character, and there may be a splashing audible even at a distance. The areas of tympany and of dullness, respectively, will be changed by altering the patient's posture.

Treatment.—Treatment is the same as for a severe attack of ordinary pericarditis. The prognosis is extremely grave. The air has been successfully removed by **aspiration** in a few cases. Surgical measures may be resorted to in some cases to close the pericardial wound.

Case of pneumopericardium due to a stiletto stab. The treatment consisted in resection of sternal portion of second rib and part of sternum, ligation of bleeding vessel, and retraction of pleura. Number 1 catgut closed up the hole in pericardium. When the writer had retracted the pleura and exposed the pericardium, a small $\frac{1}{8}$ -inch wound in the sac could be seen, and it could be observed that during every diastole of the heart air-bubbles would appear at the opening—not unlike the familiar test of a leaking automobile tire-valve, showing the pressure of air within the pericardium. The patient made an uneventful recovery. Joseph Burke (Buffalo Med. Jour., May, 1909).

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HEART, DEGENERATIVE DISORDERS OF THE.—DEFINITION.

Degenerative disorders of the heart, to which the term “**fatty heart**” is often applied, embraces two pathologically distinct affections: *Fatty degeneration*, in which there occurs a transformation of the cardiac muscle-fibers into fat; and *fatty overgrowth*, in which an abnormal quantity of fat is deposited in, or about, the heart. They include also the conditions known as *brown atrophy*, *calcareous degeneration*, *amyloid degeneration*, and *hyaline degeneration*.

FATTY DEGENERATION.

DEFINITION.—By the term fatty degeneration is meant the conversion of the cardiac muscle-fibers into fat.

SYMPTOMS.—The condition may exist in an advanced form without the production of symptoms (latent fat-heart). The presence of any causal conditions, however, should be noted, and they afford premises for suspicions, although even when symptoms during life point strongly to the existence of fatty heart it may not be revealed by an autopsy.

A fatty heart may be diagnosed if the following conditions are detected: An easily induced dyspnea in a person having an abundant deposition of fat upon the body, especially on the chest and abdomen, with a small, feeble, frequent, and easily compressed pulse, with final dilatation of the heart and diminished *ictus cordis*. A general plethora or fullness of the skin may also be present. T. Schott (Med. Record, March 24, 1900).

The characteristic evidence of defective heart power is generally present, but in pernicious anemia, chlorosis, and in certain wasting affections the fatty change may be marked, the pulse continuing full and regular while the patient is at rest. In such cases slight provocation or strong excitement leads to palpitation, leaving signs of commencing dilatation (an apical systolic murmur, with feeble, diffuse impulse). The condition is quite commonly associated with hypertrophy and chronic nephritis; it then gives rise to the phenomena that characterize failing compensation. The process is constantly associated with sclerosis of the coronaries, a clinical type which embraces most of the cases of so-called idiopathic fatty heart of the English writers. I have frequently observed that these cases manifest the same grouping of symptoms as is met with in premature senility.

Dilatation is apt to supervene early in fatty degeneration of the heart, owing to the weakened state of the cardiac walls; hence it is quite probable that many of the symptoms that have been ascribed to the morbid processes are, in reality, due to secondary dilatation. It is to be remembered that the symptoms pointing clearly to defective heart power may be in evidence only after great exertion.

A sustained pulse at once negatives advanced fatty degeneration. The evidence yielded by the heart sounds is likewise ambiguous except when their loudness negatives the condition. Relative distance from the ear, thick parietes, intervening fluid or tissue, and particularly lung tissue, will effectually mask a good second sound, which sometimes then may be best heard in the neck. The first sound may likewise be partly extinguished. Greater significance attaches to the shortening of the interval between the first and the second sound, the ventricle "not going through" with its systole, though this too is just as much a constant result of mere heart fatigue or asthenia. Slowness of the pulse, though a specially common symptom, cannot be strictly identified with the affection. No physical signs whatever are obtainable from palpation and percussion of the cardiac area. We are, practically speaking, left without a single positively identifying mark. And yet the diagnosis has to be made, and is often enough made, from the general clinical aspect of the case, and from the aspect of the patient, which taken together seldom deceive the experienced physician. Sir William Broadbent (Lancet, May 27, 1905).

Among the symptoms pointing to overdistention, either constant or temporary, of the cardiac chambers, are palpitation, dyspnea, and a small,

irregular, somewhat quickened pulse, and cool and clammy extremities. Great physical exertion may produce sudden, marked dilatation, whereupon a canter rhythm and an apical systolic murmur speedily develop, although in most instances the symptoms are brought to light in a more gradual manner.

Breathlessness on exertion, even though slight, and syncopal attacks are sometimes troublesome. There may be frequent attacks of cardiac asthma in the morning, and these may be accompanied at intervals by pains, anginoid in character, even assuming the severity of true angina. The latter complication may, however, occur independently of the asthmatic seizures. The pulse, in consequence of the irritation of the inhibitory center in the medulla, frequently becomes much retarded, declining from the normal rate to 30 or 40 beats per minute, and in rare cases to 10 or 12 beats. Disturbances of the intellect, at times assuming the form of maniacal delusions, may come on and persist for weeks and even months. The fatty *arcus senilis* possesses no diagnostic value.

Two symptoms of considerable value, particularly when combined in the same case, are pseudoapoplectic attacks, due to disturbance of the cerebral circulation, and Cheyne-Stokes respiration, the latter being among the later manifestations. When Cheyne-Stokes breathing is in association with pseudoapoplectic seizures, they are more apt to be due to a uremic toxemia, perhaps, than to fatty degeneration of the heart. According to Broadbent, a noteworthy point is that well-marked dropsy is rare, and probably never occurs in uncompli-

cated degeneration. The significance of this is that the special effect of the disease is defective pressure in the venous system, and it is to this that the syncopal, apoplectic, and epileptiform attacks are due, which, together with angina pectoris, are the most characteristic later effects of fatty degeneration. The syncopal attacks vary greatly in intensity, and are marked rather by duration than intensity, and are not attended with complete loss of consciousness. He also speaks of attacks resembling *petit mal*, attended with slow pulse, sometimes less than 20 in the minute.

As to physical signs, there is a weak, irregular impulse that often can neither be seen nor felt; later dilatation supervenes. After the latter event the impulse is apt to be diffuse. The most constant and significant feature of the pulse is that it is short and unsustained (Broadbent). The area of cardiac dullness increases, and a soft systolic murmur is often audible at the apex (relative insufficiency). When fatty degeneration is associated with marked obesity, it is difficult to delimit the area of dullness, for obvious reasons, and the cardiac sounds on auscultation are apt to be weak, distant, and muffled. On the other hand, in thin subjects and in the fatty degeneration of grave anemias, the first sound of the heart is often short, sharp (flapping in character), simulating the second sound.

Drawing upon his own experience, the writer believes that more cases of sudden death are attributable to degenerative disease of the cardiac muscle than to any other kind of heart disease, and that a number of cases occur, as the autopsy room discloses, that were never diagnosed prior to death. These structural

changes are fostered by the *wear and tear* of life. They occur in men—and sometimes in women, too—who display an indomitable energy coupled with a tireless activity in discharging great responsibilities, without sufficient rest and exercise in the open air. The degenerative changes follow what might be called a form of cardiac strain from prolonged high tension, from worry, business cares, and the like, independently of the earlier presence of an infectious disease. P. Y. Eisenberg (*Mthly. Cyclo. and Med. Bull.*, May, 1911).

DIAGNOSIS.—The diagnosis is unfortunately obscure. In a large number of cases the patient has not consulted his physician when sudden death supervenes from rupture, usually during active exertion or excitement; less frequently the termination in death follows the administration of an anesthetic or a full meal. Rarely, death follows the action of the exciting cause after the lapse of several hours.

While fatty degeneration may be a sequel of coronary disease, sudden death in the latter is in the majority of instances to be ascribed to changes in the arterial coats and not necessarily to fatty degeneration of the heart walls with ensuing rupture. Corroborative post-mortem evidence is not wanting. Key Aberg found extensive areas of fatty degeneration only in 2 instances out of 13 autopsies of sudden death from cardiac paralysis, brought about by sclerosis of the coronary arteries.

The history, particularly if this points to the existence of arteriosclerosis, the age of the patient, the symptoms of cardiac weakness and subsequent dilatation coupled with retardation of the pulse (though the

latter may be increased in frequency), apoplectic attacks, the Cheyne-Stokes respiration in the absence of antecedent hypertrophy, may be regarded as significant features. Again, with a clear history of the presence of the more characteristic symptoms, including the signs of dilatation following hypertrophy, fatty degeneration may be inferred with some degree of assurance, and yet even this state of affairs should not lead to a positive statement of opinion.

In persons having reached middle life in whom a weak and irregular action of the heart is manifested, it becomes an important question to decide whether this be due to functional disturbances or organic disease. Broadbent found that usually this is accomplished by making the patient walk briskly. A few steps will often be sufficient. If the heart is sound it rises to the occasion. The pulse and beat sounds are all more distinct, and strong and regular, whereas the fatty heart "goes to pieces," and the pulse becomes irregular and shorter than ever or may even disappear.

Fatty degeneration may follow fatty infiltration of the heart, and while in consequence of this fact the two conditions are sometimes found in association, they are to be looked upon as separate and distinct morbid processes.

Rosenfeld and others have shown that in fatty changes of the type ordinarily designated as fatty degeneration the fat contained in the degenerated cells was a true infiltration from outside the cells. The writers found that dogs fed upon lean horseflesh and mutton tallow had deposited in the fat depots of the body a fat very similar in composition to the fat of sheep. If in such dogs a "fatty degeneration" of

the myocardium was produced by phosphorus poisoning, the fat in the myocardium was found to be of the same composition as that in the rest of the body—that it, like mutton fat. If the fat were produced by a transformation of the muscle cytoplasm into fat it certainly would not be of a foreign type, like sheep's fat, and the only possible conclusion is that the fat was obtained by transference from the fat depots. Leick and Winckler (*Archiv f. exp. Path. u. Pharm.*, Bd. xlviii, 1902).

In attempting to discriminate one from the other a recognition of the differences in causation is all-important. Fatty overgrowth (see next heading) is due to and associated with polysarcia, while the leading causal factor of fatty degeneration of the heart is arteriosclerosis affecting the coronaries, or atheromatous changes in the valves or walls of the aorta, causing obstruction at the mouths of the coronaries: conditions that would lead to weakness of the cardiac walls due to degenerative change. Among favoring causes of fatty degeneration are to be reckoned all the various factors that tend to bring about arteriosclerosis, as syphilis, diabetes, and alcoholic excess, though the latter may also act primarily upon the myocardium or the blood itself. Cases of fatty heart occur independently of coronary disease. Thus, the disease coexists with pernicious anemia, chronic alcoholism, and not infrequently follows acute forms of disease, as acute aortitis and typhoid fever. In typical arsenical and phosphorus poisoning the fatty heart is constantly encountered.

The symptomatology of these two cardiac affections presents differences of considerable significance. Both may exist, however, without the pro-

duction of symptoms, and both have symptoms in common, such, for example, as dyspnea upon exertion, and arrhythmia, including reduplication. In fatty degeneration the volume of the pulse is diminished to a greater extent, and the disturbance of the pulse is also greater than in fatty infiltration. The breathlessness of fatty infiltration after exertion is associated with obesity; not so in fatty degeneration, as a rule.

The occurrence of "syncopal, apoplectiform, and epileptiform attacks" in connection with the factors of etiological importance mentioned above, points strongly to fat-degeneration, and these symptoms are attributable to insufficient pressure in the arterial tree. Mild syncopal attacks may arise in fatty overgrowth, but when they become more severe, more frequent and prolonged, and particularly with associated coldness and clamminess of the extremities and body surface, then fatty degeneration should be suspected. Much the same remarks apply to the symptom angina.

The symptoms of bronchitis and asthma, either separately or combined, are oftener met in fatty overgrowth. In the latter condition the heart sounds are weak and distant or muffled, owing to abnormal fat deposits; in fatty degeneration the sounds are short, flapping in character, due to associated dilatation, but they are clear, and an apical systolic murmur is not uncommonly audible.

The so-called therapeutic test is an aid in the discrimination. Thus, as the result of appropriate treatment for the obesity the abnormal deposits of fat in and around the heart can be made to disappear gradually, with marked or even complete relief from

the inconveniences occasioned thereby. On the other hand, slight temporary improvement, if any, is all that can be hoped for in advanced fatty degeneration, or at a time when the diagnosis is reasonably assured.

Finally, it may be said that the recognition of fatty infiltration is an easy matter, while that of fatty degeneration is scarcely possible until a late stage is reached. That form of fatty degeneration which follows compensatory hypertrophy is distinguished from fatty overgrowth by the special history, absence of obesity, and obviously dissimilar physical signs. It is to be recollected that dilatation following hypertrophy is not invariably due to fatty change.

ETIOLOGY.—Fatty degeneration may supervene in both secondary and primary forms of hypertrophy, as well as in chronic myocarditis and chronic pericarditis. The degeneration of the cardiac walls dependent upon valvular disease, Bright's disease, and general arteriosclerosis is, perhaps, more often fibroid than fatty in nature.

It is constantly met, also, in association with fatty change in other organs, in the severe forms of primary and secondary anemias, and even more commonly, though of a less severe grade, in the cachectic states produced by such chronic diseases as carcinoma and phthisis.

Recent observations have shown that fat is more widely distributed in the tissue cells than was formerly taught. In addition to the liver, intestine, suprarenals, and subcutaneous tissues, a number of the glandular organs contain a certain amount of fat as the expression of physiological activity, *e.g.*, salivary glands and pancreas, kidneys, testicles and

ovaries, thyroid and pituitary, the sweat-glands, spleen and thymus, muscles, and nervous system. When fat circulates freely in the blood-stream,—in contrast with the normal small amount,—as in the condition of lipemia, the connective tissues and parenchyma of the liver, heart, lung, spleen, kidney, and testis all contain globules of fat, although no degenerative changes can be demonstrated. Herxheimer and Walker Hall (Med. Chronicle, Aug., 1904).

Alimentary fatty heart is equivalent to the fatty infiltration of the normal heart. Some authors attach no clinical significance to this phenomenon. The heart, fatty or not, can go ahead up to the point of death without functional insufficiency. Nevertheless no one regards such a heart as normal, although the fetal heart regularly passes through this cycle. Wegelin (Berl. klin. Woch., Nov. 17, 1913).

The condition may arise in the course of acute infectious diseases of intense type, especially diphtheria and typhoid fever.

Certain toxic agents (arsenic, phosphorus, alcohol) are potent to cause a high grade of fatty degeneration. In the case of alcohol, it is only after long periods of intemperance that cardiac degeneration is established, and often only after primary coronary sclerosis. Besides sclerosis, which is an all-important etiological factor, the condition may be consequent upon a mere blocking of the mouths of these vessels.

Fatty degeneration is most common after forty years of age.

It occurs somewhat more frequently in men than in women, notwithstanding the fact that there are predisposing influences at work in the latter that do not obtain in the male sex, such as childbirth and amenorrhea.

Whatever may be its apparent etiology, it is invariably preceded by a defective nutritive supply to the muscle-cells; this may be dependent on mechanical causes, such as contraction of the lumen of the coronary vessels, or upon impairment of the oxygen-carrying power of the blood, as in the anemias, primary and secondary.

PATHOLOGY.—The process may be either general or localized. Thus, when circumscribed it may be limited to the uppermost or subpericardial layers, as when induced by pericarditis. The same minute foci and yellowish striæ may be observed in the superficial subendocardial layers, especially in the trabeculæ of the papillary muscles ("tabby-cat" striation). Blocking of one of the branches of the coronary artery (as a rule, the anterior) by a thrombus or embolus leads to the production of an anemic necrosis or white infarct, which is often composed of fatty *débris*.

In general fatty degeneration the muscular substance throughout presents a pale- or a light- yellowish appearance, and is quite friable, the finger being readily thrust into it. Rarely, the color-tint is brownish in circumscribed areas from associated brown atrophy.

Many hearts whose muscle seems normal to the naked eye are really the site of extensive fatty change, while in some instances a fatty degeneration, though widespread, may require an immersion lens to demonstrate it even in osmic-stained specimens. Examination of the cardiac muscle in osmic acid media has been neglected, so that statistical count of the frequency of fatty heart in various diseases is at the present impossible.

Fatty degeneration of the myocardium is of quite common occur-

rence; while marked cases give notable evidence of the change on macroscopic examination, in a majority it can only be diagnosticated with certainty by examining sections which have been fixed in osmic acid. J. N. Cowan (*Jour. of Pathol. and Bacteriol.*, June, 1902).

The various chambers of the heart are often enormously dilated with marked overstretching of the intracardial orifices. Coronary-artery diseases and atheroma of the arch of the aorta are among the most constant associated lesions.

In fatty degeneration the sarcous substance of the fasciculi is directly converted into globular fat, as contrasted with the condition of fatty infiltration, where the fat is deposited between the fasciculi.

Microscopically, the cell-fibers are observed to be displaced by minute granules and oil-globules, the latter first making their appearance at the poles of the muscle-nuclei; the striæ and nuclei become indistinct, and finally are wholly lost. The characteristic brown granules of brown atrophy may sometimes be visible, either at the extremities of the nuclei or uniformly distributed. The microscopic appearance of fatty degenerated muscular tissue is sometimes confounded with albuminoid degeneration, but the form may be distinguished by the characteristic brown coloration when stained with osmic acid, and also the fact that on treating a section with acetic acid the fat-globules are not thus affected, while the albuminoid granules are dissolved.

Fatty degeneration is only an example of fatty infiltration. Fat is not visible in healthy muscle because as fast as it is taken up by the protoplasm it is used to supply the energy of the cell. Tissues micro-

scopically fat-free have been found chemically to contain 20 per cent. No relation seems to exist between fatty heart and cardiac weakness. The normal heart contains 8 per cent. In phosphorus poisoning there is 25 per cent.; in pernicious anemia, 13 per cent. In nephritis, malignant tumors, and tuberculosis there is some increase, but in myocarditis and chronic valvular disease the amounts found have been normal. Experimental researches fail to show that fat interferes with muscle work. Disease of the coronary arteries is a frequent cause of insufficiency, but extreme sclerosis has been found with absence of symptoms. Fibrous myocarditis, although many times associated with coronary sclerosis, often occurs independently. All cases of muscle incompetence, however, cannot be explained on the basis of anatomical changes. In obesity increased work is thrown on the heart. Insufficiency may be due to acute overdistention from violent bodily exertion. There is no justification for attributing it to nervous disturbances or exhaustion. Circulatory disturbances in the infectious fevers are probably due to paralysis of the vasomotor center. J. H. Pratt (*Johns Hopkins Hosp. Bull.*, Oct., 1904).

The extract obtained by shaking the blood with petroleum-ether was invariably greater with immunized than with normal animals, and of the many substances which are dissolved out by the ether, the fat was especially increased. There is thus a definite relation between the bactericidal power of the blood and the amount of fat it contains. M. Hahn (*Münch. med. Woch.*, April 19, 1904).

Visually demonstrable fat is present normally in very many cells of the body, while extracted fat occurs in practically all of the tissues. Under abnormal conditions the visually demonstrable fat appears in the cells in increased amount and is always an index of cell injury. With

regard to fatty infiltration and fatty degeneration, fatty infiltration is the physiological appearance of fat in normal cells, while fatty degeneration is the appearance of fat in injured cells; the fat is an index rather than the direct result of cell degeneration. H. A. Christian (Bull. Johns Hopkins Hosp., Jan., 1905).

PROGNOSIS.—This varies in a measure with the causative disorder, but, as a rule, the more corpulent the subject, the graver the prognosis. The increasing liability to sudden death must be borne in mind, the morbid process being commonly associated with sclerosis of the coronaries. In the majority of instances, however, the end is reached in a gradual manner, the signs and symptoms of advanced dilatation closing the scene. The frequent recurrence of syncopal, pseudoapoplectic, epileptiform, and anginal attacks heralds an early fatal termination. All known remedies are without avail in restoring the integrity of the degenerated muscle-tissue.

Fatty degeneration of the heart divided into three stages. The first stage is that one in which the prognosis is most favorable; that is, if the patient does not yield to the primary disease he will probably recover with a sound heart if properly treated. In the second stage prognosis is not good for total arrest of the fatty process, but much improvement may be brought about. The third stage is marked by profound implication of the internal viscera, the prognosis is unfavorable and the end may be expected within a few months. Fatty degeneration of the heart is a common affection, but it is not to be classed as a disease *sui generis*, but as a process attending non-valvular as well as valvular affections. It is caused by fevers, toxemias, dyscrasias, disorders of nutrition and mechanical injuries, but it may be a physiological

process, as in senility or after parturition. T. E. Satterthwaite (Med. News, Feb. 2, 1901).

TREATMENT.—The cause in each individual case should be determined with precision if possible, and, if detectable, a bold attempt should be made to remove or moderate it. This course embraces in different cases many hygienic and dietetic considerations that assist in improving the nutrition of the cardiac tissue: one of the cardinal aims of a proper system of treatment.

Anemia in one form or other often plays an important etiological rôle; and the particular variety present in each case must decide the character of the special remedies to be employed. Thus, pernicious anemia would call for the exhibition of **arsenic** in gradually ascending doses to the limit of gastric tolerance; *chlorosis* would demand, in addition to an appropriate hygienic regimen, the use of **iron** (e.g., Bland's pills). In that large category of cases occurring in certain *cachexias* (cancerous or tuberculous) the following formula has, in my hands, given gratifying results:—

R *Arseni trioxidi* .. gr. j (0.065 Gm.).
Ferri sulph. gr. xxx (2.00 Gm.).
Strychninæ sulph. gr. j (0.065 Gm.).
Quininæ sulph. . 3j (4.00 Gm.).
Papoid gr. xxx (2.00 Gm.).
M. et ft. capsulæ no. xxx.
Sig.: One after mealtime.

When the signs of *cardiac dilatation* become well established, **rest** in the recumbent posture should be strictly enjoined, owing to the danger of a sudden fatal rupture of the heart, and cardiac stimulants should be administered. **Digitalis** and **strophanthus** may be selected, but should be given with extreme caution, the commenc-

ing dose being small, and increased according to the effect in the individual case. In the form of a powder or an aqueous extract it may be conveniently combined with the prescription appended above.

For sudden *heart-failure* the diffusible stimulants (**ether**, **ammonia**, and **alcohol**) are to be resorted to. If marked *arteriosclerosis* be associated, then **nitroglycerin** and the **nitrites** are to be employed.

In cases of average severity I believe that **gentle** indulgence in **physical exercise** and **light gymnastics** is beneficial, since it tends to invigorate the heart-muscle; it is to be increased in proportion to the improvement manifested in the patient's condition. Walking up ascents, however slight, is not to be advised for some time after the other, gentler methodic exercise has been commenced.

The benefits of **active gymnastics** in cases of fatty heart and allied conditions are due in part to the training of the muscles of the skeleton and vessels, but mainly to the sweeping away of obstacles accumulated at the periphery, and in some measure to reduction in the viscosity of the blood. Hasebroek (Deut. Archiv f. klin. Med., Bd. xciv, Nu. 1-2, 1908).

It sometimes happens, however, that even slight exertion is badly borne, and it should then be promptly discontinued. In the latter class of cases I have been in the habit of advising daily inhalations of **oxygen**, combined with complete **rest** and **recumbency**, with excellent results. Recourse to **massage** is also in the line of sound practice, but the sitting should not exceed half an hour in duration to begin with.

The more prominent symptoms

may require special medication. Attacks of *syncope* are most successfully controlled by the hypodermic use of the diffusible stimulants (**ammonia** or **ether**), at the same time enjoining **absolute rest**, with the head lowered. For the *angina pectoris*, the combined use, hypodermically, of **morphine** (in small doses) and **atropine** is to be preferred, except in cases in which the apoplectiform seizures, with a comatose tendency, are of frequent occurrence. Again, when the anginoid paroxysms are dependent upon coronary disease, recourse should be had to **nitroglycerin** and the **nitrites**. For the apoplectic attacks **rest** in the **recumbent** posture, with the head slightly elevated, is useful. Among therapeutic agents, **digitalis**, **ammonia**, and **ether** may be used hypodermically to stimulate the heart; it is also good practice to resort to **venesection**, withdrawing from 12 to 24 ounces of blood directly from a vein.

A strictly **horizontal position** and the application of **ice over the heart** often quickly terminates an attack of *asthma*.

The life of the sufferer may be prolonged by giving him an abundance of **sunshine** and **fresh air** in favorable weather, but exposure to severe cold must be scrupulously avoided.

The *diet* should be simple, easily assimilable, though highly nutritious. I believe it to be an excellent rule to allow **small meals** at strictly regular, **brief intervals**. A light **wine** may be taken at dinner as an aid to digestion and nutrition.

Restricted **diet** recommended, but one that is highly nutritious, thus not depending upon it for any marked reduction in weight. **Gymnastic treatment**, exercises with resistance, recommended for all forms of fatty

heart, since the resistance may be regulated to suit the weakest or the strongest heart. Rest should never be indulged in after eating. **Massage** is efficient in promoting absorption of fat. The balneological treatment is very important. The **baths** usually get down to 76° F., and are increased in length up to twenty minutes. Gradually increased concentrations of salt used in the baths. Schott (Med. Rec., March 24, 1900).

Degeneration is curable by a system of **diet** regulation. **Dechloridation** is necessary; consequently the following regimen is prescribed: Breakfast: cold, lean meat, from 2 to 4 ounces (60 to 120 Gm.); bread without salt, 2½ drams (10 Gm.); at midday, roasted meat, 2 to 4 ounces (60 to 120 Gm.); fresh vegetables, cooked in water with a little salt, 1 ounce (30 Gm.); two cups of hot, weak tea without sugar; at 4 o'clock, a cup of tea; at 7 in the evening, two eggs without salt; vegetables cooked in water, and bread without salt, 1 ounce (30 Gm.); weak tea. Diuresis may be produced by 7½ grains (0.5 Gm.) of **theobromine** three times a day. After four or five weeks the diet may be less meager, but not more than 5 ounces (150 Gm.) of bread may be taken; butter on the vegetables, wine diluted with water, and a vegetable soup at the evening meal may be allowed. If the fluids are restricted, arterial pressure will be lessened and the restricted diet will be better borne. In obese persons who are plethoric and have a feeble heart, there is usually venous stasis, and if the labor of the heart is increased by the ingestion of considerable quantities of fluid the heart will be still further weakened. By restriction of the diet the labor of the heart is made more easy, the organ beats more forcibly and disembarrasses itself of the fat which interferes with its functions; as the patient loses fat his hypertension lessens, and the increased power of his heart action disposes of the venous stasis. In cardiac

cases whose weight is above normal, this regulation of diet will often accomplish wonderful results. H. Huchard and C. Fiessinger (Amer. Jour. Med. Sci., from Jour. des praticiens, No. 13, p. 201, 1905).

The bowels should be made to move rather freely and easily by means of properly selected articles of food, and, these failing, mild **laxatives**.

(See also the treatment of the obesity in such cases at the end of the section on **FATTY DEGENERATION**.)

FATTY OVERGROWTH.

DEFINITION.—Fatty overgrowth of the heart is characterized by an abnormal accumulation of fat about the surface of the organ and the interstitial tissue. It is also termed **fatty infiltration** when the interstitial tissue is alone the seat of an abnormal deposit of fat.

Under the head of fatty heart there are at least two different conditions. There is the small heart, free from accumulation of fatty tissue upon its exterior, which is degenerate throughout, to such an extent, indeed, that the apex of the ventricle may consist of nothing but fat. There is, again, the large, heavy, thick heart, which is overlaid with fat deposited beneath the pericardium, which fills up both the transverse and longitudinal sulci, and which penetrates between the muscle-fibers of the organ, finally involving the fibers themselves. H. Hirsch (Wiener med. Woch., March 22, 1902).

SYMPTOMS.—A well-marked degree of fatty overgrowth may be unaccompanied by any symptoms, although the bodily vigor may be impaired. These cases are usually combined with general obesity.

Simple sign which is almost pathognomonic of fat-heart even at a period when other indications of its

presence are still wanting: Normally the heart sounds are less distinctly audible when an individual is in the recumbent or reclining than when in the erect position. The increase in loudness and sharpness of the heart sounds when standing is especially noticeable after moderate bodily exertion. When, on the other hand, fatty overgrowth of the heart is present, this increased loudness of the cardiac sounds when in the upright position (and after moderate exertion) either does not ensue at all or is only insignificant. Stern (Archives of Diag., July, 1912).

The muscle-fiber of the myocardium is weakened (not degenerated, as a rule), and as a consequence dilatation of the organ tends to supervene; this excites dyspnea upon exertion. Under these circumstances, if extra labor is suddenly thrown upon the organ, from any cause whatsoever, the clinical indications of a weak heart (urgent dyspnea, precordial discomfort, palpitation, vertigo, syncope, cyanosis) promptly appear and become pronounced, followed later on by recurrence on every provocation.

Distressing attacks of asthma may develop after a full meal, or in the absence of any apparent exciting cause. A passive form of bronchitis, probably secondary to a weak heart, attended with the customary symptoms,—cough and a slightly colored expectoration,—often arises.

Inspection shows a feeble, diffuse apex beat, though in marked obesity I have frequently found it absent. Palpation serves to confirm the existence of a feeble impulse, which may be occasionally missed; decided arrhythmia may be noted. The radial pulse is variable, though, as a rule, regular and moderately tense. Percussion yields dullness over an in-

creased area, although this is not demonstrable in excessive obesity. Auscultation renders audible the feeble heart sound in marked cases, and, with increasing dilatation, a systolic apical murmur. In moderate grades the heart sounds may be clear.

The urine of 996 obese patients examined, and sugar found present in 10 per cent. of that number. The percentage of diabetics seems to increase with the degree of obesity. Wolfner (Berliner klin. Woch., Jan. 28, 1901).

In **fatty infiltration**, which may be associated with grave forms of myocardial degeneration, the symptoms develop abruptly, after some unusual muscular exercise or after a profound systemic shock. More commonly, however, the clinical indications, which are not sharply defined as a rule, manifest themselves in a gradual manner. The principal features are urgent dyspnea (often an asthmatic form of breathing) and utter exhaustion upon muscular exercise, precordial discomfort, pain under the sternum, cardiac palpitation, arrhythmia, syncope, vertigo, cyanosis, and angina pectoris. Marked and constant disturbance of the cardiac rhythm is symptomatic of fatty infiltration. Hydrostatic bronchitis, with cough and expectoration, is commonly present. The angina pectoris may be dependent largely upon associated sclerosis of the arterial system. Emotional disturbance and mental apprehension are the chief nervous phenomena. The *physical signs* are neither constant nor characteristic; they are, in the main, those of cardiac dilatation. The *pulse* may be regular and of good tension, but after dilatation comes on it becomes irregular, frequent, and easily compressible.

Moderate hypertrophy probably exists in the majority of cases, but cannot always be demonstrated owing to the extreme subpericardial overfatness. A basic systolic murmur may be heard; it is not due to valvulitis as a rule.

DIFFERENTIAL DIAGNOSIS.—

The diagnosis rests upon the combined presence of marked obesity and a weak heart. Although there is little danger of confounding fatty overgrowth with other cardiac affections, the fact is to be kept in remembrance that its persistence favors the occurrence of fatty degeneration, and it is not always possible to discern the sequence, since, as will appear hereafter, fatty degeneration may exist without engendering symptoms.

Certain points of distinction will be found in the division on FATTY DEGENERATION.

ETIOLOGY.—The chief etiological factor is general corpulency. Among conditions *predisposing* to fat-production may be mentioned: (a) Heredity: in about 50 per cent. of the cases of obesity the tendency is inherited, and in these the abnormal accumulation of fat shows itself quite early in life. (b) Climate: corpulence occurs with relatively increased frequency among the inhabitants of hot, moist countries, and of low countries of the temperate and Arctic regions. (c) Habit and occupation: the sedentary habits of the rest-loving, phlegmatic temperament predispose to fat-increase, while all sedentary occupations act in a similar manner. (d) Race: Jews are particularly subject to obesity, and the same may be said of races inhabiting certain hot, moist climates (*vide supra*); e.g., southern Italians, South-Pacific Islanders, and certain African peoples.

(e) Age and sex: acquired obesity most frequently arises in persons of advanced middle life, between 40 and 50 years, while the congenital form is seen in infancy and childhood. The fat-heart is never found in infancy (Cutler). Corpulency is more frequent among women (particularly Jewesses) than among men, and in the former sex it often appears at puberty and between the thirtieth and fortieth years. (f) Certain diseases and conditions may predispose (anemia, paraplegia, and loss of blood and of other fluids. (g) Congenital anomalies and monstrosities (idiots, cretins, acephali).

The *exciting causes* may be tabulated as follows: 1. Inebriety; the intemperate use of alcoholic beverages, especially in the form of beer, ale, porter, and the like. 2. Ingestion of fat-making food in excess. Excessive use of fats, starches, and sugars, although the too free indulgence in proteids may also be responsible, especially with insufficient physical exercise. 3. The prolonged use of arsenic may sometimes lead to corpulence.

The nutrition of the body and the maintenance of it at a given weight are regulated by a nervous mechanism, in the same way that the heat of the body is controlled. It is essentially a condition of altered metamorphosis closely allied to gout, diabetes, chlorosis, myxedema, and arrests of development. Habitually more food is taken than is needed to maintain the nutrition of the tissues and in the ordinary oxidation for the production of energy. The remaining food is oxidized and gotten rid of under the regulating influences of the nervous system. Debove (La Semaine méd., March 13, 1901).

PATHOLOGY.—The characteristic change consists in an abnormal

deposit of fat, more especially in places where this tissue-element is normally found, as the auriculoventricular grooves, near to the apex, and about the great vessels at the base. This overproduction of fat is present in every obese person, and when excessive may form an enveloping mantle, first covering the right ventricle, later the left also, attaining a diameter of an inch or more. The surface of the fat-heart generally presents a pale-yellow hue, but may be a deep-yellow color, resembling sulphur. The intermuscular fibrous tissue, as may be seen on section, is the seat also of increased accumulation of fat. In extreme cases the muscular fibers undergo atrophy, thus becoming weakened, from inordinate pressure.

Dilatation often supervenes, and it is quite probable that the symptoms, when present, are dependent upon, and date from the time of, its occurrence. Rupture of the organ is also not unlikely. A coronary artery and the aortic arch are often arteriosclerotic. In the cachexias of carcinoma and phthisis, and in the general atrophy of the aged, fatty infiltration and fatty degeneration coexist.

PROGNOSIS.—Cases in which fatty degeneration has not as yet been set up afford a favorable prognosis, especially if the cause be removable. On the other hand, in long-standing cases of excessive obesity, more or less fatty change of the muscle-fiber may be safely inferred to exist, and the outlook is dubious, though much will depend upon the special cause and its degree of removability, as well as the presence or absence of serious complications. Among the latter, the more important are arteriosclerosis,

albuminuria, glycosuria, anginal attacks, pulmonary congestion, edema, and the like. Permanent results are not always attainable in cases dependent upon the patients' habits, since the latter are liable to relapse into them after a variable degree of improvement.

In fatty infiltration, especially when associated with forms of myocardial degeneration, the prognosis as to cure is almost hopeless, although marked improvement may follow appropriate treatment. A fatal termination is often due to spontaneous rupture of the heart.

TREATMENT.—**Prophylaxis.**—Although such cases generally first come under observation too late to receive the benefits of prophylactic measures, there are, nevertheless, many favorable opportunities presented to the wise family physician to attend to this important matter, even in the earlier years of those showing an hereditary predisposition to obesity. The fat-forming foods, particularly the carbohydrates, must be greatly restricted in the **dietary**. The amount of **liquid** must also be **diminished**, as a rule.

Case of a young woman with a nervous taint whose weight fluctuated remarkably at times independently of the amount of food consumed. The difference was evidently due to retention of fluid, though there was no actual edema, and displayed unmistakable connection with emotional stress and the onset of the menses. Between morning and night the patient's waist and bust measure would sometimes increase so that she was unable to get into her clothes. Bernouilli (*Correspondenzblatt f. schweizer Aerzte*, March 10, 1910).

Fats and proteids are allowable, and their proportions must be regulated

according to the amount of muscular activity. **Systematic exercise**, in the fresh, open air, along with **cool baths**, are measures to be adopted. Persons in middle life who manifest a predisposition to corpulency should be cautioned against all imprudences in eating and drinking; they should pursue a prescribed dietary, in which not only the character, but the quantities, of the various substances allowed should be noted. If there be the slightest tendency toward anemia, an **open-air existence**, short of injurious exposure, is imperative. **Gymnastics** and **outdoor sports**, if wisely regulated, should play a part in the prophylactic management of these cases. If anemia be associated with fatty overgrowth, then greater care and caution must be exercised in recommending physical exercise, the amount of **liquid** may be much **diminished**, and the fat-forming dishes should be rigidly excluded. I have long been prescribing **arsenic**, **strychnine**, and **iron**, in small doses, in such cases.

Treatment of Fatty Overgrowth.—The **system** introduced by **Oertel**, as I have observed personally, promises excellent results if faithfully carried out. Among contraindications that should be heeded are marked atheroma and chronic valvular disease of the heart, particularly in cases that have passed into the stage of broken compensation. The method will be briefly described. It comprises three parts:—

1. The **reduction of the amount of liquid** taken with the meals and during the intervals, the total for each day being 36 ounces (1064.0). Additionally, **frequent bathing**, and in suitable cases the **Turkish bath** and

pilocarpine, are employed to induce free diaphoresis.

2. The **diet** is composed **largely of proteids**, as follows:—

Morning.—A cup of coffee or tea, with a little milk—about 6 ounces (180.0) altogether; bread, 3 ounces (93.0).

Noon.—Three to 4 ounces (90.0 to 120.0) of soup; 7 to 8 ounces (218.0 to 248.0) of roast beef, veal, game, or poultry, salad or a light vegetable, a little fish; 1 ounce (32.0) of bread or farinaceous pudding; 3 to 6 ounces (93.0 to 186.0) of fruit for dessert. No liquids at this meal, as a rule, but in hot weather 6 ounces (180.0) of light wine may be taken.

Afternoon.—Six ounces (180.0) of coffee or tea, with as much water. An ounce of bread as an indulgence.

Evening.—One or two soft-boiled eggs, 1 ounce (32.0) of bread, perhaps a small slice of cheese, salad, and fruit; 6 to 8 ounces (180.0 to 240.0) of wine, with 4 or 5 ounces (120.0 to 150.0) of water (Yeo).

3. **Graduated exercise** up slight elevations and inclines, the distance to be undertaken each day being carefully specified, beginning with slight efforts and frequently, though gradually, increasing them. A similar plan is to be pursued with reference to the degree of inclination, and it is to be recollected that this is the most important part of the Oertel system, since it directly and methodically invigorates the heart-muscles.

Case of fatty heart in a woman of 40, weighing 220 pounds, who had been asthmatic and suffered from *delirium cordis*, and from time to time anginoid attacks. Similar case in a woman of 50, who weighed 310 pounds, in whom there was, besides extreme dyspnea, cyanosis and ex-

haustion on exertion. In the latter appropriate treatment reduced the weight 125 pounds, and the patient recovered. Fatty infiltration of the pericardium probably existed in this and other cases reported in which reduction of weight caused very marked improvement. Anders (Amer. Jour. Med. Sci., April, 1901).

Antifat cures are dangerous in this class of cases, and, as a rule, thyroid gland is not well borne. Care should be taken not to produce too rapid emaciation, thus allowing the heart to gradually adjust itself to its improved condition.

The writer can recall more than one instance in which the appearance of cardiac incompetency followed very promptly an antifat cure. It is particularly true in people of middle age. In persons younger, say under 40, reduction cures are safer and yet not wholly without danger. But in persons who have passed 40 any attempt to effect weight reduction by starvation diet and by vigorous exercise is certainly injurious for the reason that in such persons the cardiac system has suffered more or less degeneration. R. H. Babcock (Boston Med. and Surg. Jour., Sept. 3, 1908).

Extreme and too rapid starvation of the heart muscle is positively dangerous to life in those with organic heart disease or those who are weak or well advanced in years. Starvation may increase the adynamia of the heart from the loss of tone of the muscular fiber. There are worse conditions than superfluous flesh. R. G. Curtin (Boston Med. and Surg. Jour., Sept. 3, 1908).

RUPTURE OF THE HEART.

Rupture of the heart occurs rarely. The rupture may be *complete*, in which condition there is complete solution of continuity of the total diameter of the myocardium; or *partial*, the latter including laceration of

the trabeculæ ventriculi whereby the chordæ are liberated. Occasionally the papillary muscles are torn, causing valvular incompetency.

SYMPTOMS.—In most instances rupture of the heart results in sudden death. Sometimes, however, the patient survives the accident for several hours or even for as many days. The symptoms are those of internal bleeding, and pain that may be agonizing and is referred to the heart. The body-temperature falls, the skin surface becomes pale and cool, and it may be covered with cold perspiration, while the pulse grows small, very frequent, and finally almost vanishes. Occasionally gastrointestinal symptoms and syncope tending to convulsions appear in consequence of the irritation of the vagus centers due to cerebral anemia. The physical signs of cardiac failure rapidly develop, and, if the leak be not too large, those of pericardial effusion more gradually.

DIAGNOSIS.—Heart-anguish, rapidly progressive cardiac failure, the evidence of internal hemorrhage, and the speedy development of the signs of pericardial effusion should always excite suspicion of rupture, and in many cases suffice for a correct inference.

ETIOLOGY.—Predisposing and exciting causes may both be at work. The former are the more important and named in the order of their frequency of occurrence are,—disease of the coronary arteries (with associated anemic necrosis and abscesses), fatty degeneration, chronic myocarditis, parietal tumors, and parasites in the heart-wall.

The influence of age is notable; rupture of the heart usually occurs after

the sixtieth year has been passed. Males suffer somewhat more frequently than females. The exciting cause is, as a rule, some form of muscular exertion, though it may occur during sleep.

PATHOLOGY.—The most frequent seat of rupture is the anterior wall of the left ventricle, though it may also occur in the right ventricle and in the auricles. The rent runs parallel with the muscular fibers, and is to a certain extent the result of laceration, although chiefly of a separation, of the fibers. The fissural communication presents irregular edges, and at autopsy is seen to contain blood-clots; the pericardial sac is also occupied by coagula. If pericardial adhesions have previously obliterated the cavity, the escaped blood-clots may occupy the pleural cavity. Histological examination of the adjacent muscle-structure shows the characteristic changes of fatty and other forms of degeneration.

The **PROGNOSIS** is hopeless unless surgical measures can be resorted to. When immediately fatal, death is the result of heart-shock; it may result from anemia of the brain or compression of the heart by the effused blood.

TREATMENT.—*Prophylaxis* is of the utmost importance. The physician should give ample warning of the dangers connected with muscular strain of whatever sort. If rupture has either occurred or is suspected, the patient must be put at **complete rest in the horizontal position**. Full doses of **morphine** should be given **hypodermically**, and the **ice-bag** locally applied. **Warmth to the extremities** may be useful. The use of cardiac stimulants will be attended

with increased bleeding from the rent, but agents that relax the peripheral arterioles, such as **nitroglycerin**, may be employed with a view to diminishing the heart's labor without diminishing its power. Should the rupture be partial and the hemorrhage slight, the patient's life may be prolonged, or even saved, by keeping him at absolute rest for a long period. The patient should be afforded the chances of recovery which **surgical measures** sometimes procure, the case being treated as one of stab-wound. (See Vol. III, p. 150.)

BROWN ATROPHY OF THE HEART.

This is a form of degeneration in which accumulations of yellowish-brown pigment-granules occur in the muscular fibers. The color exhibited by the heart-muscle is a reddish brown, and in pronounced cases a dark-red brown. Brown atrophy is most commonly seen in the hearts of the aged, though also quite often in cases of chronic valvular disease that have reached an advanced stage.

CALCAREOUS DEGENERATION OR CALCIFICATION OF THE HEART.

Calcareous infiltration of the muscular fibers of the myocardium has been observed, though very rarely. In a recorded case by Bramwell, there were, besides calcareous degeneration of the heart, subcutaneous tumors in the axillæ, elbows, groins, natal folds, and popliteal spaces, with symptoms suggestive of Addison's disease, in a young man aged 25 affected with advanced cirrhosis of the left kidney, the right kidney having been completely destroyed fourteen years previously by a pyelonephritis. Somewhat more

common are the bony callosities that result from myocardial abscesses, in the course of circumscribed myocarditis.

AMYLOID DEGENERATION.

This is a pathological condition rarely met with. It is limited to the blood-vessels and interstitial connective tissue; its causes are the same as those of amyloid degeneration of other viscera. Closely allied with this condition, though occurring independently in prolonged fevers, is *hyaline degeneration*. Here the fibers are swollen, translucent, and homogeneous and their striæ almost obliterated.

Case of amyloid disease of the heart and digestive tract in a strong and healthy person who was attacked suddenly with gastrointestinal derangement and symptoms pointing to loss of compensation. In six months extreme cachexia developed, a copious intestinal hemorrhage proving fatal. On autopsy extensive amyloid and hyaline infiltrations were found in the myocardium in the form of miliary nodules, and in the submucosa of the stomach and the intestines, without any evident cause. The occurrence of both hyaline and amyloid tissue together gives strength to the theory that they are closely allied. F. Steinhaus (Zeit. f. klin. Med., Bd. xlv, Nu. 5-6, 1902).

JAMES M. ANDERS,
Philadelphia.

HEART, GRAPHIC METHODS IN THE EXAMINATION OF THE.—

Graphic methods are chiefly used in medicine to record tracings of cardiovascular, respiratory, and muscular movements.

POLYGRAPHY.—Polygraphy is a method of recording two or more tracings simultaneously on kymographic paper actuated by a motive

force, usually clockwork or electricity. The paper is attached to the surface of a metal drum, or sometimes to two drums. Of the tracings one may be made to mark the intervals of time in seconds or fractions of seconds. Kymographic paper is usually white with a smoked surface, the tracings made by the pen-arm or stylet revealing the paper and so appearing as white. This method records the precise length of a cardiac cycle, the several events being registered in waves and depressions. By this means a number of features of the circulation that were formerly unknown to us are disclosed. The tracings are truthful records of events, subject, however, to errors produced by defective instruments, sometimes by artefacts that cannot always be avoided, and also by lack of skill on the part of the operator. So, too, where there is an unusual combination of cardiac arrhythmias, even an expert may be in doubt as to the proper interpretation of each wave, wavelet, or depression.

Despite these drawbacks, tracings are fairly comprehensible registers of the various cardiovascular activities. In fact, polygraphy can be used effectively to determine the action of drugs, food, and drink on the human organism, and also such other therapeutic agencies as baths, muscular exercises, massage, and electricity. As will be shown, it is also a material aid in the diagnosis of cardiac disease.

In arrhythmias it has led to a new classification. At the present time polygraphy is the most reliable guide we have in determining abnormal cardiac conditions. It is therefore helpful in indicating appropriate lines of treatment.

The sphygmograph alone is, however, of comparatively little value, because there has never been any close agreement among physiologists and clinicians as to all the characteristics of a normal sphygmogram, nor as to distinctive curves in the various forms of valvular disease.

[This conclusion I reached as early as 1882, when I took the matter up at the Presbyterian Hospital of New York City. Though at that time most of my colleagues were of the opinion reached by Rosenstein in 1876, that no differentiation in valvular diseases can be made by any sphygmograph, a single one of them clung to the notion that aortic regurgitation had a distinctive style of curve. My experience showed me at that time that even on this point such an opinion was erroneous. T. E. SATTERTHWAITE.]

Sphygmograms are lacking in accuracy because the personal equation cannot be eliminated. To secure a good tracing the exploratory button or base must be placed directly over the radial, so as to press it against the bone. This is not easy. Besides, a certain, but indeterminate degree of pressure must be employed, and, inasmuch as it is impossible to adjust the button precisely in the same spot or to use exactly the same amount of pressure in each instance, the tracings will vary in successive tests. Indeed, there is no such thing as a standard normal sphygmogram. Age, the degree of vitality, and sex are also some of the factors that cause variations of the sphygmogram in health. Similarly, there can never be any fixed standard for the tracings of the various diseases of the cardiovascular system. As each individual differs from another in health, so, even in the same disease, and in successive examinations, there are differences

which will be recorded in the sphygmogram. One has but to compare the several tracings in health and in valvular diseases as given by Eichhorst, Colbeck, Mahomed, Strümpell, Fagge, Michael Foster, and others to assure himself that my statement is substantiated by their experience. Even in a single examination, the tracings will show appreciable differences, as will be shown in Fig. 2. The same statements are applicable to the cardiogram, only the variations are even more noticeable.

Yet, the sphygmograph has its uses. In fact, we cannot well dispense with it, even though its field is comparatively narrow. It may be relied on to give the frequency of the pulse, when the finger is unable to count it. It will give a rough record of some cardiac arrhythmias. It is competent, moreover, to detect auricular fibrillation without any other appliance, if we rely on recent experimental researches (Lewis). But it will not indicate the grade and quality of arterial tension as well as the trained finger. As a key, however, to the interpretation of the jugular pulse, its tracings are most important, and in simultaneous records of the jugular, carotid, and radial pulses and the apex beat it affords a better criterion as to time than the carotid, because it is more easily isolated from the surrounding tissues.

In the field of polygraphy, we must, for the present at least, be satisfied if its records give us practical assistance, even if they differ. Their accuracy is comparative. The case is much the same as that of the sextant which the captain of a ship uses to find his position when out of

sight of land. He cannot, except by the merest chance, determine the precise position of his ship, because he has no stationary mark to assist him, but he nevertheless usually locates his position on the chart with a sufficient degree of accuracy for practical purposes. The analogy holds good with many of the instruments in use in medical practice. They assist us materially in framing our diagnoses. Of all the graphic instruments the electrocardiograph is the most accurate, and yet the character of its curves varies according to the

and letters used in these illustrations will be those of the English system, as used by Lewis. Unfortunately, there has been hitherto no uniform system of notation, and much confusion has resulted. The accepted intervals of time in Figs. 1 and 2 are those of Mackenzie, who makes the cycle occupy $\frac{1200}{1000}$ seconds, while Michael Foster puts it at $\frac{1130}{1000}$ seconds. The latter observer puts the duration of ventricular systole at $\frac{451}{1000}$ and the duration of ventricular diastole at $\frac{679}{1000}$ second. Lewis puts the length of the cycle at $\frac{1010}{1000}$ seconds, the ventricular systole at $\frac{540}{1000}$ second, and the ventricular diastole at $\frac{470}{1000}$ second. Of course, the length of the cycle varies with the frequency of the pulse. If a pulse of 72 has

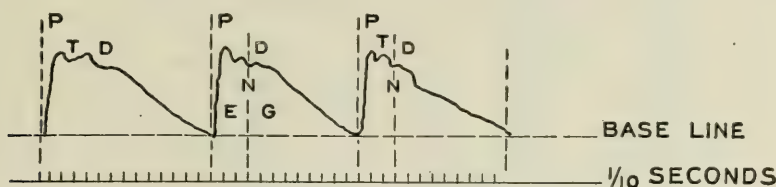


Fig. 1.—Schematic plan of a normal sphygmogram.

so-called "leads" that are used,—a point that is now generally recognized.

In Fig. 1 is shown the scheme of a normal sphygmogram in a healthy man with a pulse of 72. The space *E* marks the period of ventricular systole, which in this instance occupies about $\frac{3}{10}$ second. This is the sphygmie, or pulse, period. The space *G* marks the ventricular diastole, and occupies about $\frac{9}{10}$ second. The nearly vertical upstrokes *PP* are known as the percussion waves; the tidal waves *TT* follow. At *DD* are seen the dicotic waves, while *NN* represent the dicotic notches. An imaginary line runs horizontally through the lowest points of the upstrokes, and is known as the base line, while under it the intervals of time are marked by the chronograph in seconds and fractions of a second. The waves, wavelets, and notches and their time relations to one another are of great importance in deciphering the significance of a jugular tracing such as is seen in Fig. 2.

As far as possible, both the numbers

a cyclic length of $\frac{12}{10}$ seconds, a pulse of 60 will have a cyclic length of $\frac{10}{10}$, or 1, second. More than this, and as a corollary to what has already been said, there is no absolutely fixed relation in time between the periods of ventricular systole and diastole of either ventricle, carotid, or radial, as may be seen by measuring these intervals in Fig. 2 with a pair of dividers.

In Fig. 2 the carotid wave shows a nearly vertical upstroke, due to the sudden rise of blood-pressure caused by ventricular systole. It is followed by a long and irregular downstroke, due to the gradual fall of blood-pressure. The first or tidal wave is due to secondary contraction and expansion of the artery immediately after its primary systolic contraction. The second wave, called the recoil or dicotic wave, is caused by the recoil of the blood column due to the closure of the aortic valves. The carotid upstroke precedes the radial upstroke from $\frac{1}{10}$ to $\frac{3}{10}$ second.

In the jugular pulse, *A* is the auricular wave, *C* the carotid wave, and *V* the ventricular wave; *X* is the carotid depression

and X' the auricular depression, while Y is the ventricular depression.

The numerals 1 to 6 refer to contemporaneous events in the four tracings, so that their effects can be plainly observed in each case. At 1, auricular systole is seen in the jugular. At 2, ventricular systole begins in the ventricles. At 3, the aortic and pulmonary valves open. At 4, the radial is seen to be contracting about $\frac{1}{10}$ to $\frac{1}{20}$ second after the carotid. At 5, the aortic and pulmonary valves are closing. Between 1 and 3 is the interval between the beginning of the auricular systole and the opening of the aortic valves. It is known as the A - C interval.

stroke (5-6). The upstroke marks the beginning of ventricular systole, and may be preceded by a minor wave (A) due to systole of the left auricle. Ordinarily the cardiogram fails to show this auricular undulation, but faint indications of it may be seen in the radial tracing of this polygram. It is usually well shown in the electrocardiogram. The sloping line of the apex tracing (5-6) is often rippled by other subsidiary waves. Chronologically, the systolic plateau corresponds to the impact of the heart against the parietes during ventricular systole, and from this summit the downstroke falls with moderate obliquity to the base line. The wave

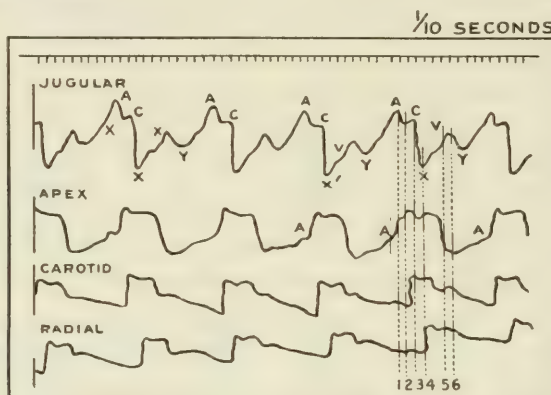


Fig. 2.—Simultaneous tracings of jugular, radial, and carotid pulses and apex beat. An adaptation of a Mackenzie polygram in a healthy man with a pulse of 72, where the length of the cardiac cycle is $\frac{12}{10}$ second.

Apart from the two normal oscillations of the downstroke, as seen in the radial and carotid, there are other miniature waves, some of which are referable to the inherent elasticity of the arterial walls, and some to instrumental or other causes, such as auricular or ventricular fibrillation. It will be seen that the apex of the normal arterial tracing (Fig. 1), or the angle between the upstroke and downstroke, is nearly that of a right angle, while of the two minor downstroke waves the recoil is more conspicuous than the tidal. This angle in many cases is quite acute, as may be seen in this illustration.

The cardiogram, shown by the tracing of the apex of the ventricle in Fig. 2, consists of a nearly perpendicular upstroke, a nearly horizontal line, the systolic plateau (3-5), and an oblique down-

stroke (5-6). The upstroke marks the beginning of ventricular systole, and may be preceded by a minor wave (A) due to systole of the left auricle. Ordinarily the cardiogram fails to show this auricular undulation, but faint indications of it may be seen in the radial tracing of this polygram. It is usually well shown in the electrocardiogram. The sloping line of the apex tracing (5-6) is often rippled by other subsidiary waves. Chronologically, the systolic plateau corresponds to the impact of the heart against the parietes during ventricular systole, and from this summit the downstroke falls with moderate obliquity to the base line. The wave

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following immediately after the downstroke (5) coincides with ventricular diastole.

The phlebogram, as illustrated by the jugular tracing in Fig. 2, is composed of three distinct waves. The first of these, the auricular, or A , wave, anticipates ventricular systole, being coincidental with the contraction of the auricles. The second wave (C), commonly called the carotid, is to be attributed to the communicated impact of the carotid artery. The third wave (V) is known as the ventricular; it corresponds in time with the diastolic wave in the radial. The notch after the A wave marks relaxation of the auricle; that after the C wave denotes auricular diastole; that succeeding the V wave indicates ventricular diastole and the passive period of the cardiac cycle. The A - C interval is the in-

terval between the beginning of the auricular systole and the opening of the aortic valves, typified by the carotid waves in the tracings of the jugular pulse. (Figs. 2, 5, and 8.) This *A-C* interval is usually about $\frac{1}{6}$ second.

When there is the ventricular type of jugular pulse, the jugular pulse corresponds in time to the systole of the ventricles, *i.e.*, venous systole and venous diastole are contemporaneous with ventricular systole and diastole. Contrary to opinions that have heretofore been expressed, the venous pulse can usually be found and registered, though the method is not always easy (Barringer). Anything that produces increased venous pressure, such as intrathoracic tumors or abdominal pressure, or lying down is likely to cause prominence of veins such as the jugular.

Fig. 3, adapted from Lewis, gives a schematic representation of the waves and depressions of the carotid, aortic, ventricular, auricular, and jugular beats, as compared with the electrographic tracing. The several curves are a compound made up of many tracings in individuals whose pulse is set at 60. The length of the cycle is therefore 1 second. It will be noted that in the auricular and jugular tracings there is much variation as to the nature of the waves; also that in the electrocardiogram both the waves *R* and *T* anticipate in time the auricular and final ventricular waves as seen in the ventricular tracing. The *P*, *R*, and *T* of this electrocardiogram correspond to the *A*, *J*, and *F* of the Einthoven electrocardiogram. It is supposed that the electrogram registers the contractions of the papillary muscles, which precede those of the main part of the heart wall.

Fig. 3 gives a fairly correct view of the contemporaneous happenings in the different cycles, though, as has already been said, there is such a variation in any individual in the length of the cycle and in the prominence and position of the waves and depressions that no one of the tracings can be considered as more than approximately correct.

Now, the cardiogram, which is the record of the apex beat, taken either

immediately over the seat of the visible impulse, in the fifth interspace or in its vicinity, in the second, third, or fourth space, or in the epigastrium, helps us also to interpret the venous pulse tracing. The cardiogram can, besides, indicate whether the left or the right ventricle makes the impact,

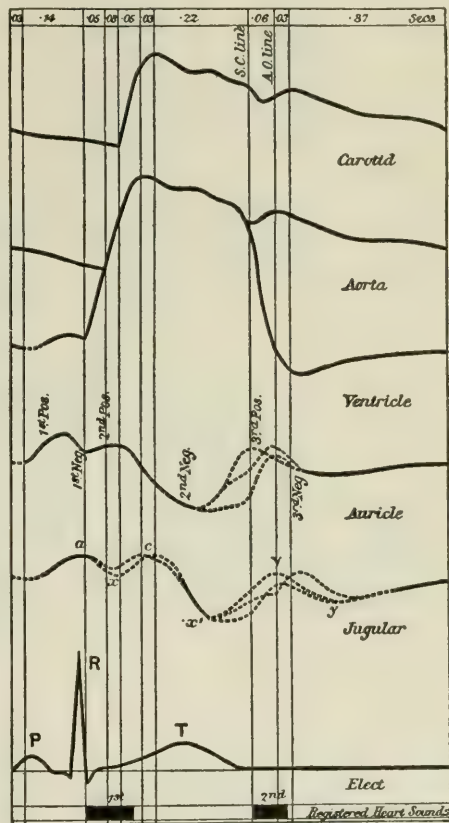


Fig. 3.—Diagrammatic representation of tracings taken simultaneously. (After Lewis.)

for when the right apex makes the impact the tracing is inverted. (See Fig. 9.) When the apex beat is not clearly felt, a tracing of it may sometimes be obtained in the epigastrium, but it may be necessary to put the patient in the sitting position.

The phlebogram gives the record of only the right ventricle and right auricle, while the sphygmogram gives

the record of both the left ventricle and left auricle. Polygraphic methods thus give a record of events in the four chambers of the heart.

as in Fig. 5, where the auricular impulse is shown at *a* and the carotid at *c*.

It is necessary to be particular and not place the receiver over the carotid. If there is a vessel in the neck that is promi-

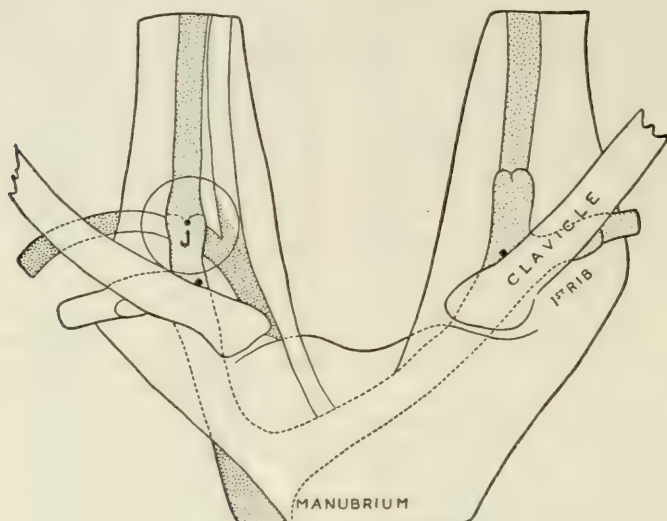


Fig. 4.—*J*, site of the jugular bulb. (After Mackenzie.)

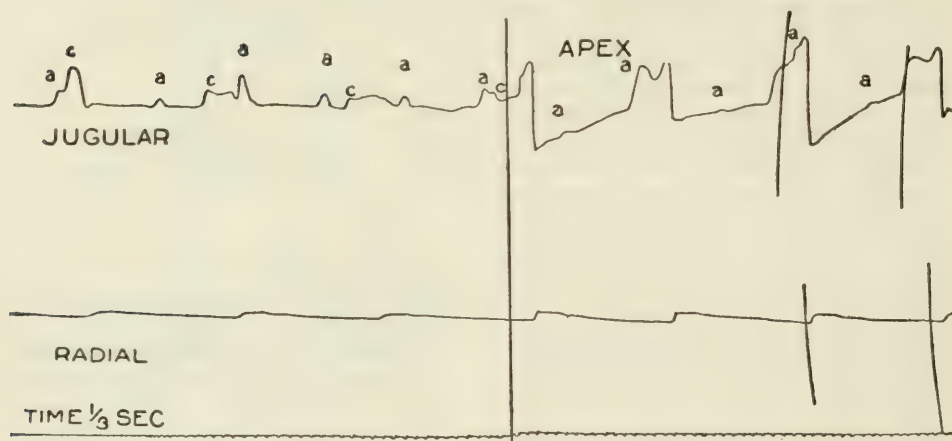


Fig. 5.—In this illustration is seen on the right the tracing of the apex (left ventricle). The waves at *c* denote the impression recorded on the jugular tracing by the action of the carotid. The case is one of complete heart block, the ventricles and auricles operating quite independently of each other, as seen by the total lack of uniformity in the *a-c* intervals. This tracing was taken immediately over the point of cardiac impact by T. B. Barringer, Jr.

Fig. 5 shows a combined jugular and carotid tracing, for if the receiver is placed over the jugular bulb, on the right side (Fig. 4), it is practically impossible to eliminate the pulsation of the carotid, which thus appears in the jugular tracing,

and pulsating it is the jugular, though as a rule it is not visible, being covered by skin, more or less fat tissue, and the sternomastoid. Examination is best made with the patient lying on the back with the head turned to the left.

The method of analyzing the jugular tracing in a normal radial pulse of 72 is as follows (Fig. 6): Make a downstroke at right angles to the time-marking line, at the beginning of the radial upstroke

responds to the middle wave; in fact, it makes this wave. It is, accordingly, to be marked C. Now measure the distance from the beginning of the tracing to 3. Measure a like distance off in the jugular,

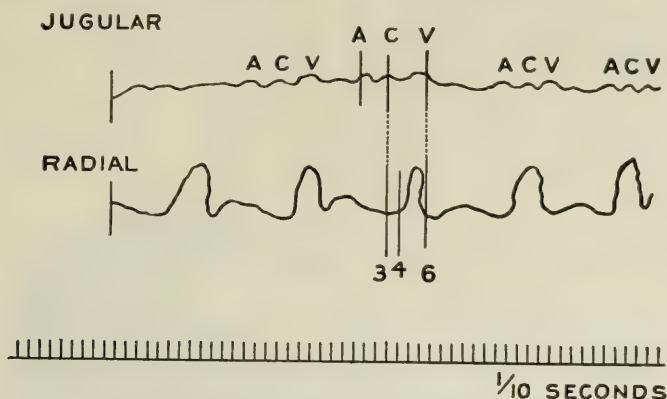


Fig. 6.—Method of deciphering the jugular pulse.

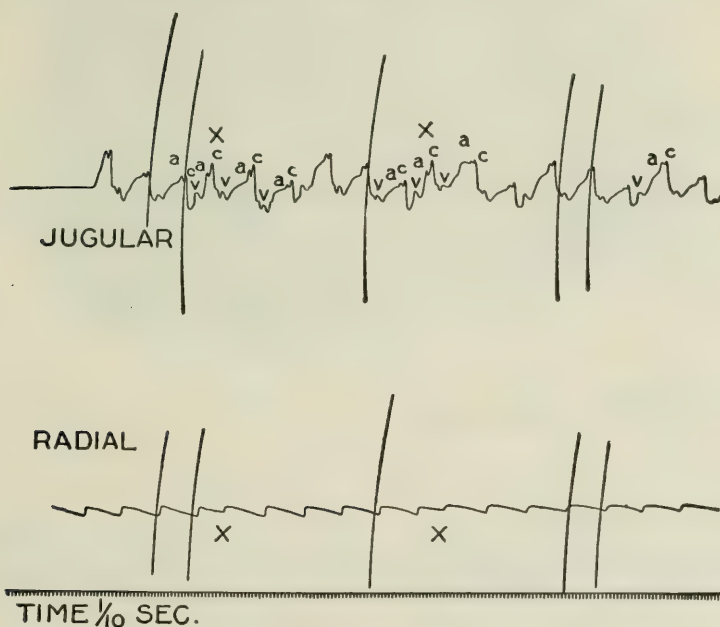


Fig. 7.—Extrasystolic arrhythmia of the auricular type. The letter *a* indicates auricular contraction of the right auricle; *c* the carotid wave, and *v* the ventricular wave. At *X* are extrasystoles of the auricular type. Tracings taken by T. B. Barringer, Jr.

marked 4. Then draw another vertical line $\frac{1}{10}$ second or so in advance of it, so as to pass through the top of the middle jugular wave of the three in series. The carotid wave, as we have seen, anticipates the radial by $\frac{1}{10}$ to $\frac{2}{10}$ second, and cor-

and it should strike the top of the middle wave. This is a corroborative indication that the letter *C* is correctly placed. But the auricular systole occurs about $\frac{2}{10}$ second earlier. Draw a vertical line about $\frac{1}{10}$ second further in advance; let the line

pass through the crest of the wave, and the wave of auricular systole is thereby located. Mark it *A*.

The dicrotic notch, which corresponds approximately to the top of the third jugular wave, marks the closure of the tricuspid and mitral valves. Mark this point with the letter *V*.

be noted that in 12 seconds only about one-half the beats have any considerable degree of force. In the jugular tracing, which is not shown, auricular systole was contemporaneous with the apex beat, showing the ventricular type of auricular systole.

It was thought until recently that the

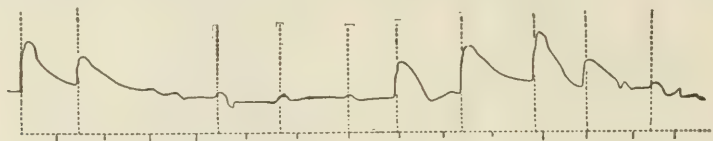
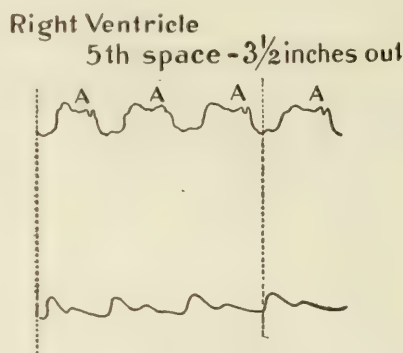
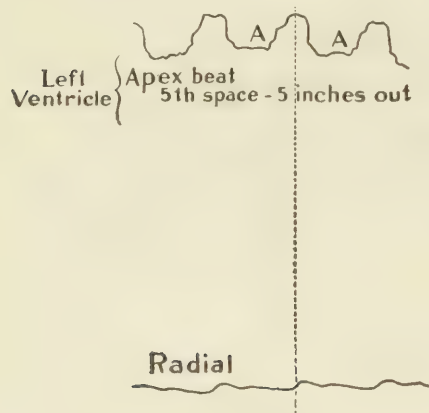


Fig. 8.—Auricular fibrillation with partial heart block in a male with Adams-Stokes disease. Pulse 30. Time markings in seconds and tenths of seconds.

These three letters are the keys to the interpretation of the jugular pulse; the letters indicating the depressions, as shown in Fig. 2, can be added if need be.

In Fig. 7 the signs $\times \times$ denote extrasystoles. As already shown, the record

venous pulse could not invariably be traced, but Dr. Barringer has taken it in 25 successive young persons with normal hearts. Dr. Barringer made them run up three flights of stairs, and then used a rather shallow receiver of a special type.



Time $\frac{1}{4}$ second

Fig. 9.—Cardiogram of a normal heart, showing on the left a tracing of the left ventricle, while on the right there is a tracing of the right ventricle, which in such cases is always inverted. Taken by T. B. Barringer, Jr.

of the venous pulse discloses more features than a record of the arterial pulse.

In Fig. 8, a tracing taken by the author, it will be seen that no two of the successive apex beats have the same length. This is, therefore, an example of auricular fibrillation. It generally occurs with the frequent pulse, when, in my experience, the prognosis is more grave. It will also

But he emphasizes the fact that the right sternomastoid must be in a state of complete relaxation, which is produced by a proper position of the head.

It may be necessary to temporarily suspend the respiration, if the respiratory curve becomes too prominent in the tracing, or it may even be necessary to take the jugular pulse on the left side.

The ordinary polygraphic machine is fitted with one or more delicate levers, each tipped with a stylet, and attached to a tambour with rubber membrane connected by a rubber tube with a receiver, which, when placed over the pulsating area, transmits the undulations to its stylet. The lever, with or without the tip or stylet, forms the so-called pen-arm, and is made to rest lightly on the surface of the kymographic paper, which is usu-

drums, and immersed in a solution either of shellac and alcohol or of benzoinum and alcohol (1 oz. in 10 oz.), after which it is hung up to dry, and then laid on a flat surface, protected from the dust. This is the best method to follow, as unless it is spread out flat before becoming fully dry the paper is apt to curl up in drying.

Mackenzie recommends two instruments for clinical work: the clinical polygraph and the ink-writing polygraph.

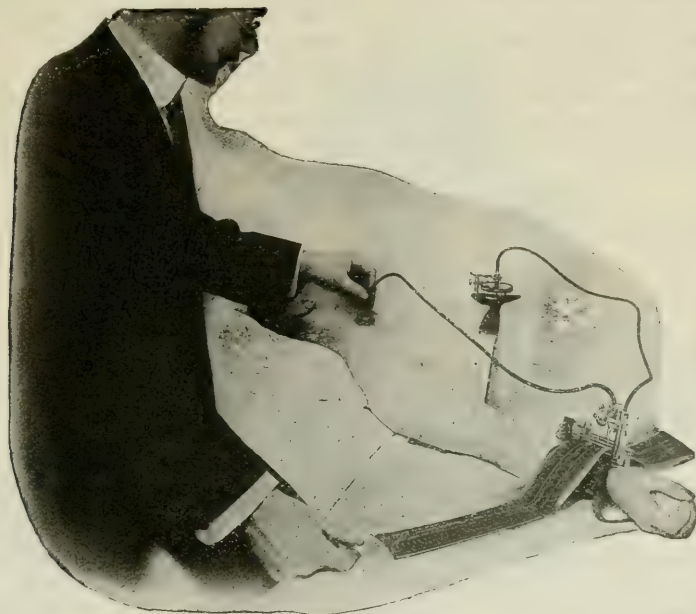


Fig. 10.—Taking a phlebogram, sphygmogram, and cardiogram simultaneously by the instrument.

ally smoked. As the paper is actuated by clockwork, or in the laboratory by an electric motor, it moves at uniform speed, while the oscillations of the pen-arm on the carbonized film make the graphic tracing.

In order to interpret the several tracings of the polygram, a chronograph, or time-marker, is necessary. This also is actuated by clockwork or electricity. After the polygram has been made, it is to be suitably labeled with the name of the patient, the date, and the locality. Afterward, the numerals and letters required for purposes of interpretation are inserted in their appropriate places. Next, the paper is carefully removed from the drum or

Both are portable. In hospital and laboratory work, larger and more complete instruments are necessary; these are, of course, more accurate, but their size and weight make them too bulky for ordinary clinical work.

When the tracing is about to be made, the patient should, as a rule, be placed in a comfortable reclining or horizontal position, with the head bent slightly on the chest. Then the operator marks with a dermatographic pencil the site of the right radial artery, just above the styloid process of the radius. The mark should be placed where the vessel is most prominent. The wrist is put at rest in an easy position, and the pad of the machine ap-

plied to the spot marked. The rubber tube is then attached to the lever, the tip of the pen-arm is approximated to the surface of the smoked paper, and the spring connected with the lever is so regulated as to get the required amplitude for the excursions of the pen-arm.

To get the jugular pulse, apply the receiver—which is a brass cup, perforated with a minute hole to allow the escape of air when applied—over the jugular bulb on the right side, at the spot (*J*) indicated in Fig. 4.

Occasionally, as I have said, it may be better to apply the receiver on the left side or higher up. The other end of the tube should be attached to the pen-arm and approximated to the kymographic paper.

In the obese, and in women with pendulous breasts, there may be no visible apex beat. In pronounced myocardial diseases it is apt to be absent. Whenever the cup or receiver is used, the finger must cover the minute air hole while the tracing is being made, so that the full force of the column of air will be transmitted to the tambour.

In taking respiratory movements such as are seen in Fig. 11, bind an ordinary rubber bag to the chest, attaching to it a tube and tambour; the respiratory movements will be traced on the moving smoked paper.

The Jaquet polygraphic machine, known as the sphygmocardiograph, is excellent for clinical work. It may be purchased of the Arthur H. Thomas Company, of Phila-

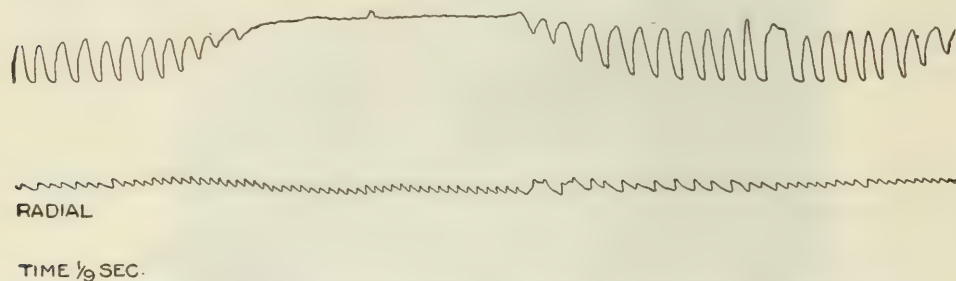


Fig. 11.—Cheyne-Stokes respiration. Taken by T. B. Barringer, Jr.

In getting the liver pulse, a special receiver is required. It should be large and oblong. After the knees of the patient have been drawn up, it is applied to the surface of the liver, being pushed up under the free border of the ribs. To this receiver one end of the rubber tube is attached and the other to the pen-arm and tambour.

A somewhat similar receiver is placed over the apex of the heart, where it is bound down by a circular band (Fig. 10). All of the pen-arms are firmly attached to a vertical metal support, which is firmly clamped to a table, bracket, or some other object that is immovable.

To record the carotid pulse, the receiver is placed at about the level of the thyroid cartilage, or at the level of the hyoid bone, on the right side. The chin should be elevated and the head turned to the left, in order that the carotid may be easily reached by the receiver.

delphia. This instrument is compact, comparatively easy to operate, and capable of registering three tracings. Though these are miniatures of the tracings made by large laboratory kymographs, they give the prominent details.

Jaquet's sphygmocardiograph (Fig. 12) is provided with a small metal plate which rests on the subject's radial artery, and is attached to a lever system carrying at its free end a delicate stylet for registering the movements of the radial pulse. A second stylet and lever system plays upon a tambour, and leads by a rubber tube to a special receiver designed for the cardiac apex or other thoracic pulsations, which is held in place by a chest strap. A third registering mechanism of similar construction communicates with a cup-shaped receiver used for transmitting the jugular impulse; a fourth, actuated by separate clockwork, marks the time. When, after adjustment, the three stylets

rise and fall with proper amplitude, indicating that the different undulations will be satisfactorily registered, the operator starts the chronograph and sets the strip in motion, adjusting it to run its whole length, while an assistant catches the paper as it passes from the rolls and guide wheels, so that it emerges without hitch from the instrument.

Marey's polygraph is bulky, but accurate; its cost is \$120, duty paid.

Gibson's polygraph takes four simul-

seconds and at *c* for fifths of seconds, after which the lever is released, and the pen-arm writes the time divisions on the paper.

Probably the best polygraphic machine for research work is that of Dr. T. B. Barringer, of New York.

The Dressler-Beard Manufacturing Company, of New York, is now making an improved Mackenzie ink polygraph.

This instrument consists of a body, which comprises the apparatus for keep-

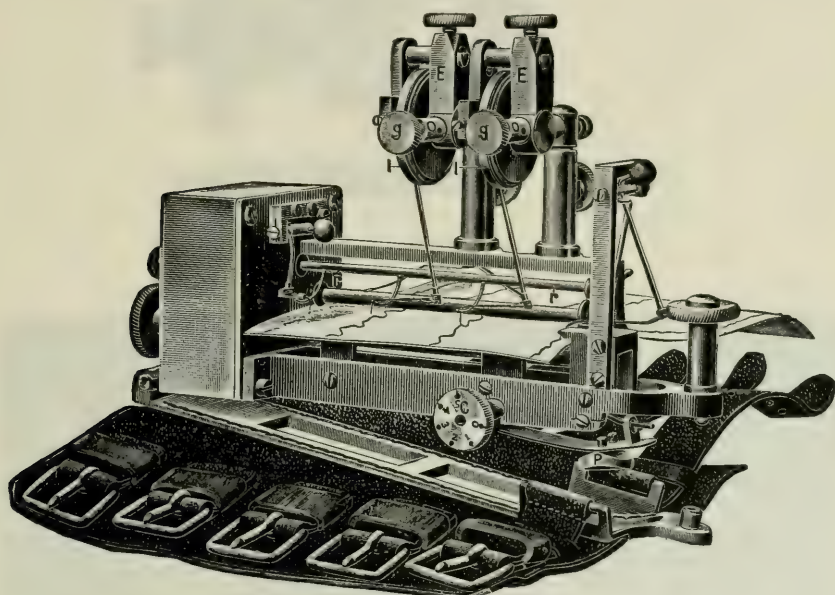


Fig. 12.—Jaquet's sphygmocardiograph.

taneous ink tracings on glazed paper, but is more expensive than either of the two already mentioned. There are also numerous other instruments, such as those of Dudgeon, Frey, Richardson, and Mackenzie.

One of the best time-markers is the Jaquet, shown in Fig. 13. It can be used in connection with any polygraphic machine. When the pen-arm (*d*) is applied to the surface of the kymographic paper, it will record time tracings with intervals of seconds and fifths of seconds. It is operated by clockwork, the dials of which are shown in the cut. When the instrument has been attached to the vertical rod at *A* and clamped in position by the screw, pressure is made on the button *b* for

ing the paper in motion at a uniform speed, with guards or discs to keep the course of the paper straight; a time marker recording in fifths of seconds, and a speed regulator. Attached to the body by a bracket are three tambours for receiving arterial or venous pulsations or the cardiac impulse. Each tambour is fitted with a pen-arm, and the latter with split pens, each having at its extremity a small inkwell. The receivers for the venous pulse or heart beat are shallow metal cups of the Mackenzie type, each fitted in its roof with a nipple, to which is attached the rubber tubing that connects it with a tambour and writing lever or pen-arm. To secure the radial tracing a sphygmograph is used. It consists of a

tambour attached to a splint, which is strapped to the wrist and fitted with a tongue and button, by which the radial pulse is transmitted to the tambour of the body and so to the writing lever and pen. This instrument is well suited for clinical work, is easily portable, and is inexpen-

on the dial (Fig. 15, *A*), which is then able to record the cardiovascular waves automatically on the smoked paper of a revolving drum (*B*). The name cardiovascular is given to these tracings because they represent the action of heart and vessels conjointly. The pen-arm, made

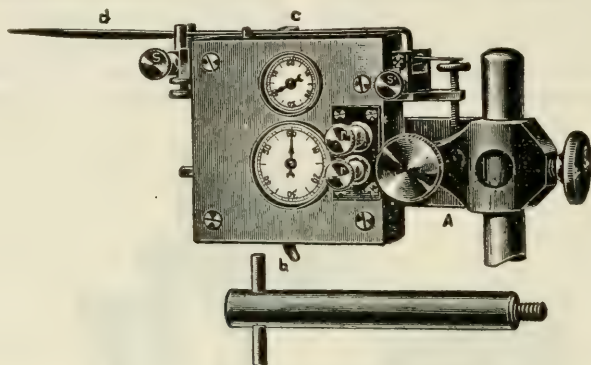


Fig. 13.—Jaquet chronograph.

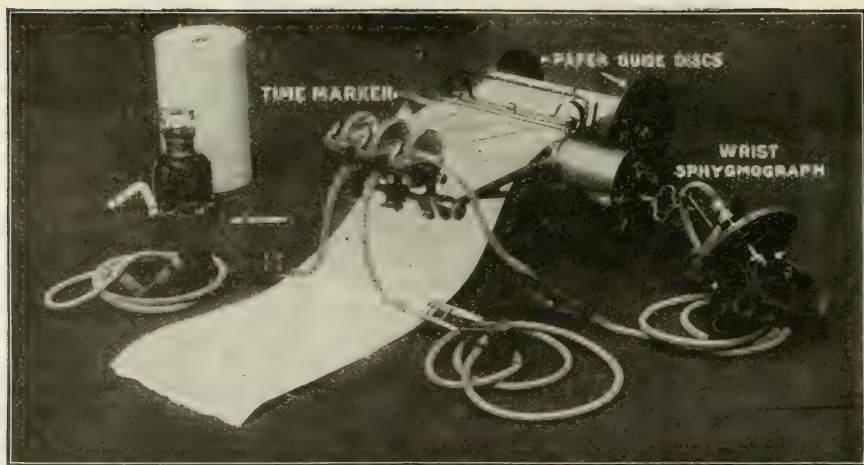


Fig. 14.—Modified Mackenzie ink polygraph.

sive as compared with some of the foreign instruments.

For more than seven years I have been using in my office an automatic lever and spring recording polygraph.

The pen-arm of the machine is actuated automatically by the levers and spring of the ordinary bathroom or office scales, on the platform of which the patient stands. The action of the heart and blood-vessels is communicated to the special pen-arm

of aluminum, is heavily shaded in the diagram. Below it, another pen-arm, made of rye straw and tipped with platinum, celluloid, or tin foil, receives the impulse of the carotid or jugular, or liver pulse, or of the apex beat, as may be desired, through a brass receiver (*D*), and writes the curve on the same paper. Still below this, the metal pen-arm of a Jaquet chronograph (*C*) or an electric time marker may register the time simul-

taneously on the drum in seconds or fractions of seconds.

If we accept Einthoven's explanation of the significance of the waves of the electrocardiogram, as given below (see Fig. 23), the interpretation of these tracings is as follows. The tall or vertical stroke indicates the ventricular systole; the second represents ventricular contraction, or the tidal wave; the third wave the end of ventricular contraction, or the dicrotic wave. The fourth and fifth waves represent auricular contraction. The sixth wave, if it exists, indicates the activity of His's muscle bundle.

It will be noted that there is a fair degree of coincidence between the general characteristics of the tracings made by the two machines.

While the automatic lever and spring instrument is capable of doing the work of an ordinary polygraphic machine, aided by the usual receivers, tubes, tambours, and pen-arms of polygraphic machines, I have used it more especially in studying the effects of nicotine, spirit of nitroglycerin, and caffeine on the human subject, in respect to the rapidity, duration, and force of their action on the circulatory system. In these experiments polygrams are able to furnish with reasonable accuracy a graphic record of the rate and rhythm of pulse and respiration, and of their comparative force, before, during, and after the several experiments. The requisite measurements for the determination of these several items are taken with calipers and a millimeter rule.

It will be noticed in Fig. 16 that in two instances (at ++) all the waves of the Einthoven tracing are shown, including the sixth or His wave, supposed to be due to the contraction of the His bundle, or Gaskell's bridge. In the middle tracing the time abscissæ are recorded in quarters of seconds by the electric time marker. In the lower tracing the time abscissæ are in fifths of seconds by the Jaquet time marker.

In Fig. 17 the upper tracing by the automatic recorder is the cardiovascular. The lower tracing, by the electric time marker, records time in $\frac{1}{4}$ and $\frac{1}{20}$ seconds.

In this way also a comparison can be instituted between control experiments

and the direct ones. The recorder represents a new kind of instrument, particularly applicable to the study of pharmacodynamics.

So far as I know, this and the electrocardiographic machines are the

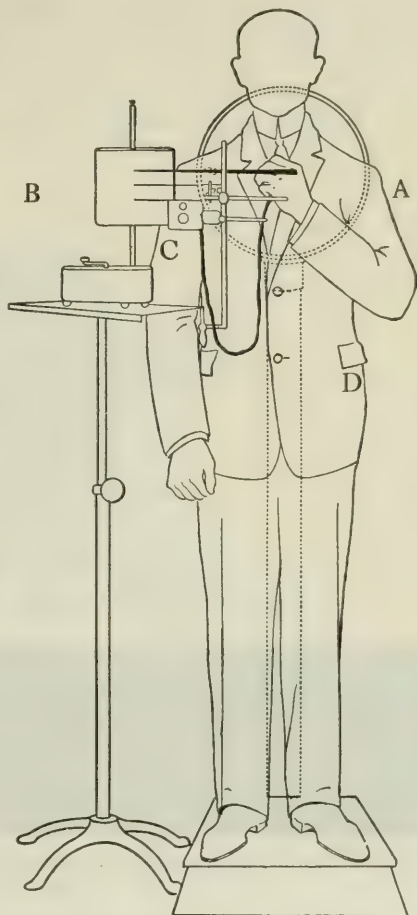


Fig. 15.—Automatic lever and spring polygraphic machine or recorder.

only instruments that register automatically the successive events in a cardiac cycle. All instruments that use the sphygmogram introduce a personal equation that makes their tracings of doubtful accuracy. The distinctness of the respiratory curve, as seen in Fig. 18, is also a note-

worthy feature of this automatic recorder.

ELECTROGRAPHY AND ELECTROCARDIOGRAMS.—Muscle tissue, in the performance of its functions, evokes three things: (1) animal action or motion; (2) animal warmth; (3) animal electricity. The

first who actually demonstrated it, confirmation coming from Kölliker and Remak, working independently, in 1850.

During the last ten years, however, electrocardiography has been utilized both in medical and commercial circles. In fact, it was Ader's

Fig. 16.

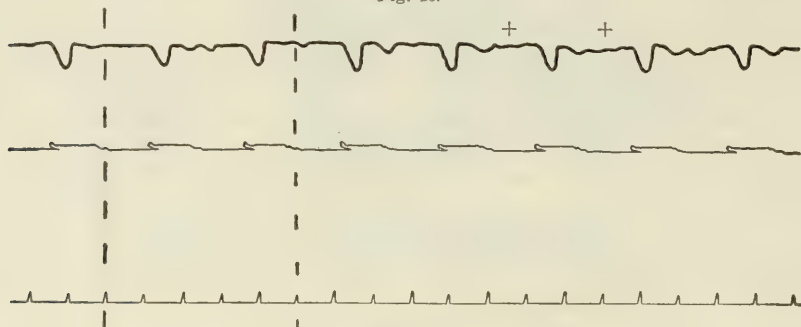
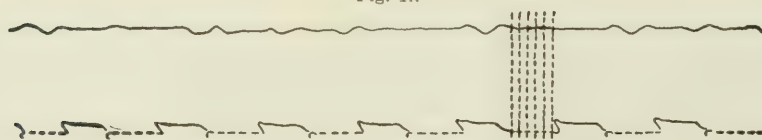


Fig. 17.



Figs. 16 and 17.—Cardiovascular waves as taken by the automatic recorder.

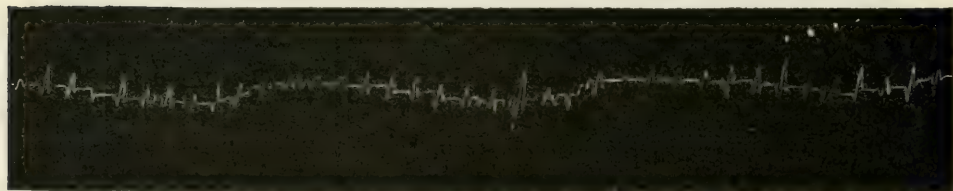


Fig. 18.—Cardiovascular tracing, showing an irregular respiratory curve, in a pulse irregular as to force and rhythm.

first of these is, of course, the most important to the economy. As compared with it, the production of animal warmth and electricity are insignificant.

That electrical currents emanate from contracting muscular tissue was foreshadowed by Harvey when he published his "*Exercitatio Anatomica de Motu Cordis*," etc., in 1628. But Matteuci, in 1843, was apparently the

registration machine, as applied to submarine cable work, brought into notice in 1897, that led to the construction of the string galvanometer which is an essential element in the electrographic machine.

The instrument most in favor, made by Edelmann & Son, of Munich, utilizes the Einthoven or string galvanometer. It should be stated parenthetically, however, that Lippmann, in 1873, by his invention of the capillary electrometer, had already

furnished the idea of a hypersensitive capillary electrometer.

The idea of registering the action of heart muscle depends upon the fact that there is a ratio between the contracting force of certain heart muscles and the current that emanates from them. This fact was discovered by H. Waller, of England, as early as 1887. Putting it in another way, electrical currents are to some extent measures of the muscular action of the heart's chambers.

hind which was a moving sensitive plate upon which were photographed the oscillations of the column. But Marey's work was overlooked. Between 1887 and 1889 Waller was developing his capillary electrometer that registered the heart's action. Altogether it has taken two-thirds of a century to complete the Einthoven machine of the present day.

For the string galvanometer is the standard instrument, and that of Einthoven, of Leyden, is the one in general

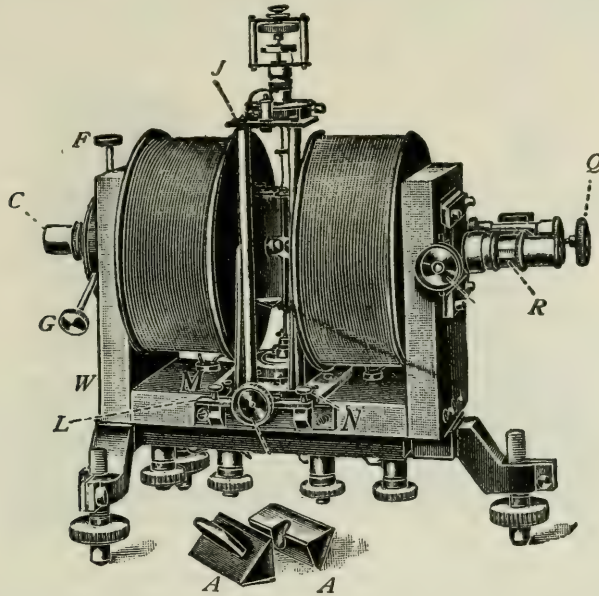


Fig. 19.—The Einthoven galvanometer, electromagnets, and microscope.

Now, as already said, Matteucci discovered, in 1843, that electromotive force emanated autochthonously from the heart. DuBois Reymond confirmed this discovery, in 1849, by the use of a very delicate galvanometer, Remak and Kölliker following, as already stated, in 1850. Müller and Kölliker showed later (1850-1856) that there was a special current developed in the auricles during their contraction.

Lippmann, however, in 1873, appears, in addition to his invention of the capillary electrometer, to have been the first to devise a registering apparatus, though Marey, of Paris, subsequently made a very good recording instrument. The latter was able to throw the shadow of a moving column of mercury on an open space be-

use. Ader used at first a capillary galvanometer made of fine copper or aluminum wire which was suspended at right angles to the poles of a permanent magnet. He used a wire as much as 100 cm. long, in order to have large excursions. The diameter of the wire was about $\frac{2}{100}$ mm.

Ader, in 1897 (*Comptes-rendus de l'Acad. des Sci.*, vol. cxxiv, p. 1440, 1897), devised his instrument, known as Ader's receptor, to supersede those of Thomson (Lord Kelvin), known respectively as the mirror receiver and the siphon recorder. By the mirror method the electric current passed through a large coil within which was a copper tube containing a magnetized needle hung by a short thread before a mirror. The needle oscillated

under the action of the currents, and the operator sitting before the mirror read the dispatch as he would read the Morse alphabet. This instrument has, however, been superseded by the siphon recorder, used very largely at the present time by the transatlantic Commercial Cable Company, of New York. It was invented by Thomson, in 1867 (*Bright's Submarine Recorder*, p. 630).

The siphon recorder apparatus consists of a very light coil of wire suspended between the two poles of an electromagnet, and capable of turning on its vertical axis. According to the direction of the current,

once, on the same paper, into the Morse code, while another operator sitting opposite reads the Morse message and simultaneously typewrites it into the ordinary message.

Now, in the Ader recorder a long vertical wire, through which the current passes, is stretched in a magnetic field, and is drawn from side to side by the poles of the magnet, while a ray of light from a lamp throws the shadow of a minute portion of the moving wire on a moving strip of photographic paper in the form of an undulatory dotted line. This method has been used extensively by some

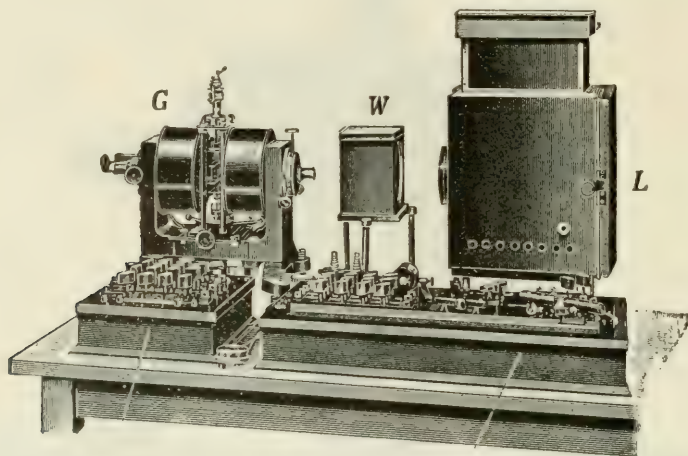


Fig. 20.—The Einthoven electrocardiographic machine fitted to a table.

the coil turns one way or the other. The motion of this coil is transferred to a capillary glass siphon, one end of which is bathed in ink while the other is approximated to a slip of paper moved by clockwork. The ink being connected with a small electrostatic machine and the paper with the earth, the ink is attracted to the paper, and issues from the capillary tube with a rapid succession of spurts. When the siphon is at rest it writes a straight line on the moving paper,—in this instance a tape,—but when actuated by positive and negative currents it oscillates from one side to the other, and the deviations above and below an imaginary line correspond to the dots and dashes of the Morse code. An operator reading the marks on the paper, as they pass by clockwork before him, converts them at

of the French submarine cable companies, while the Einthoven machine is an adaptation of it for electrographic work in heart disease.

But Einthoven, the inventor, and Edelmann, the manufacturer, have improved on the Ader galvanometer. Einthoven's is now usually made of silvered quartz. Other instruments to accomplish a like purpose are made in Cambridge, England (Lewis), by the Cambridge Scientific Instrument Company; by Wertheim-Solomonsen, of Amsterdam; by Lorenz, of Berlin, and by Kunsch and Jaeger, of Rixdorf. The poles of the magnet are perforated and illuminated, and the galvanometer, suspended at right angles to the perforations, is charged by the current of the magnetic field, while a portion of the shadow of the vibrating wire, magnified

by a microscopic lens, is thrown on the moving sensitive plate and photographed.

As the open space is a very narrow slit and the wire is at right angles to it, the shadow thrown on the paper is that of a minute quadrilateral. Now, this little quadrilateral, a mere speck, vibrates back and forth, throwing its shadows on the moving plate, the successive vibrations corresponding to the particular cardiac muscle that contracts. The greatest contraction, which is that of the ventricles, forms the high notch in the tracing; the smaller notch that precedes the bigger one is the contraction of the auricles. The tracing does not distinguish between the right and left ventricles, or right and left auricles, but records the sum of the contractions of the two ventricles and two auricles. These are the main characteristics of every tracing. There are subordinate notches to be described later.

The electromagnets, constituting the north and south poles, are fed by an accumulator battery of about 10 volts, which is a necessary part of the outfit. The principle on which the galvanometer works is that an electric conductor actuated by a current placed in a magnetic field at right angles to the magnetic current oscillates forward and backward, according as the current is ascending or descending, as with the oscillating current of the street supply. The amount of oscillation depends on the strength of the magnetic field, the strength of the street current, and the resistance.

But besides the accumulator battery, the machine requires a "null" apparatus. For when the hands or arms or feet are immersed in salt water, a so-called "null" or body current develops, and it has to be eliminated or "compensated for" in some way. Accordingly on the table of the machine there is a "null" apparatus, or "condenser," which must be placed in the line of the electric current.

Another apparatus to be fitted to the table is an appliance for regulating the voltage or amperage. Wheatstone's bridge is also used in addition for estimating the resistance of the electrodes and the body of the patient.

In Fig. 19 is seen an Einthoven galvanometer (*J*), suspended between the poles

of 2 electrodes. The electromagnets are wound with copper wire, and set in an iron frame (*W*), supported on adjustable feet (*DD*). A microscope (*R*) pierces the axis of the magnets, and is illuminated by a lighting appliance (*C*). An apochromatic lens is fitted into the tube *R*, and another into the tube *C*. The first magnifies, and the second casts the shadow on the sensitive plate, operating through a narrow cleft which causes the shadow in the form of a minute right-angled speck to write on the plate as it vibrates back and forth. It is no easy matter to throw

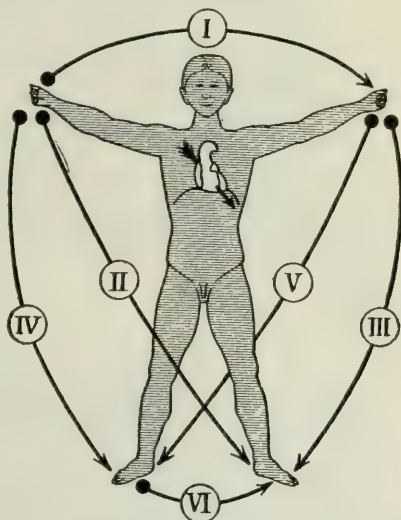


Fig. 21.—The six leads. (Kraus and Nicolai.)

the shadow on the paper. Careful adjustments have to be made of the micrometer screws (*L* and *Q*), so as to throw the shadow into the middle of the field, while the adjusting micrometers (*G* and *F*) have to be turned until all color defects have been eliminated. The plugs (*AA*) are used to shut off light currents of air, etc., that might disturb the electric currents.

Accordingly, for heart work, there is needed to make the apparatus complete: (1) A string galvanometer; (2) a lamp; (3) electrodes; (4) an accumulator battery; (5) an apparatus for testing the susceptibility of the galvanometer; (6) an apparatus for compensating the "null" element"; (7) a photo-registering apparatus; (8) an achromatic microscope.

In Fig. 20 there is seen at *L* an electric

arc lamp, the intensity of the flame being regulated by adjusting screws. At *W* is seen the water-bath used to absorb the heat rays of the lamp. At *G* is the galvanometer suspended between the poles

the electric current generated in the muscles of the cardiac chambers is much like that of the currents that pass over the surface of the heart, as to direction. We know that the left ventricle and right

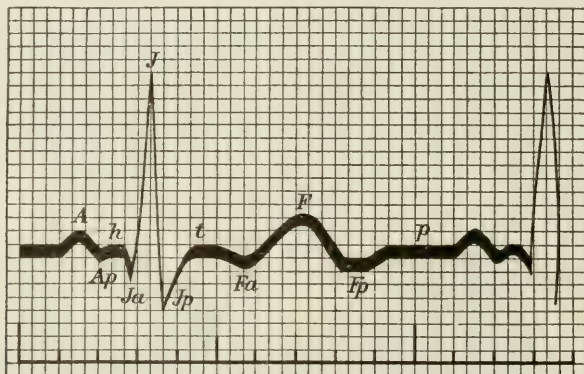


Fig. 22.—Einthoven's schematic representation of the successive events in the cardiac cycle of an electrocardiogram. *A*, auricular wave; *h*, small wave indicating activity of His's muscle bundle; *J*, large initial wave of ventricular contraction; *t*, secondary contraction of ventricle; *F*, final larger wave of ventricular contraction; *P*, period of cardiac inaction, preceded by an imperfect wave. *Ap*, *Ja*, *Jp*, *Fa*, *Fp*, negative waves following muscle contractions. The rectangular rulings of this diagram enable the reader to estimate Einthoven's conception of the comparative dimensions of the several events in a cardiac cycle.

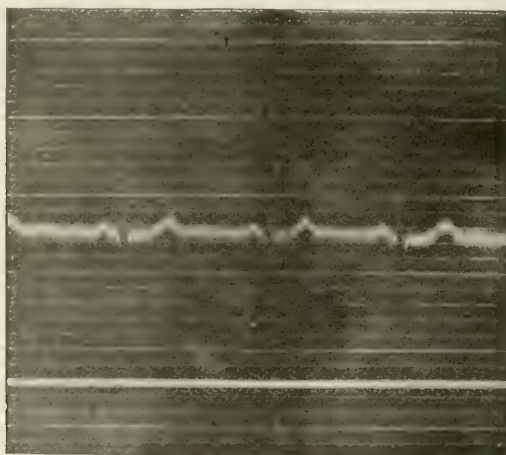


Fig. 23.—Electrocardiogram of a normal heart taken by a lead through the right arm and left leg. (Lead II.) A 1000-volt current and a 1-cm. excursion of the needle on the screen were employed. This tracing was taken in the laboratory of the Mechanicophysical Institute of Franzensbad, during the summer of 1910.

of the magnets. Alongside of these are the accumulator batteries, while under the lamp and water-bath are the "null" apparatus and the apparatus for testing the sensitiveness of the galvanometer.

Now, as a matter of fact, the course of

auricle are the heart chambers nearest to the surface of the body, and we also know by animal experimentation that the current through both arms is quite like the current emanating from these two points in the heart. But the current shown at II

(Fig. 21), which passes from the right arm to the left leg, gives the best tracing, as a rule. That is, by referring to the standard of the normal heart *II* represents the tracing that is accepted for the normal heart. In lead *III* the waves *A*, *J*,

order to secure a tracing of auricular fibrillation. It is customary in marking any tracing to indicate on it the course of the current, whether as in *I*, *II*, *III*, etc., up to *VI*. In Fig. 21 the course of the currents used is shown; for example, in *I*,

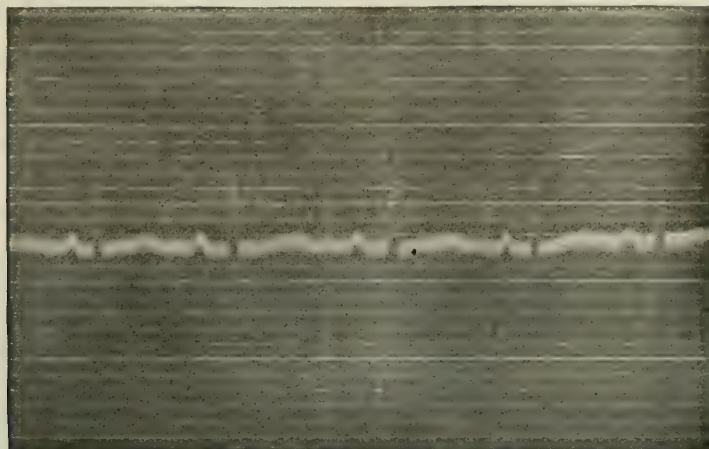


Fig. 24.—Electrocardiogram in a case of aortic aneurism, as shown by the Röntgen ray, with clinical signs of aortic and mitral insufficiency. There is seen to be moderately strong initial contraction of the ventricles, but well-pronounced contraction of the auricles. The final contraction of the ventricles is not well marked, but the rhythm is fairly good. (Franzensbad, August 10, 1910.)

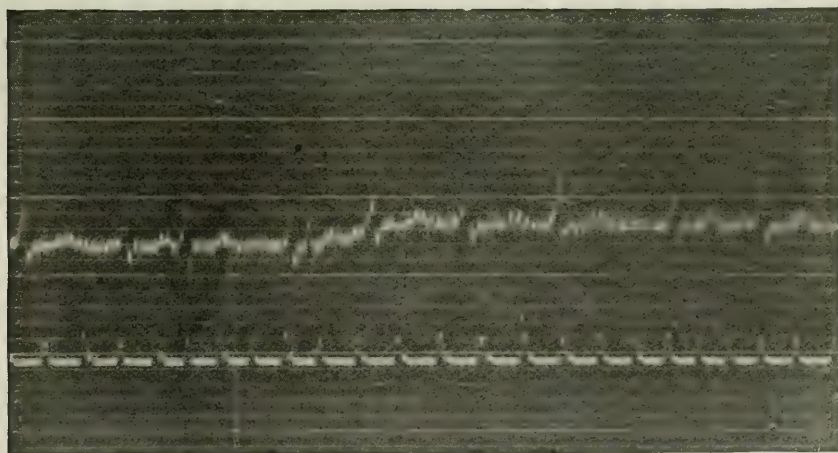


Fig. 25.—Myocardial degeneration. Irregularity in action of ventricles and auricles. Extra-ventricular systole. Diminished ventricular contraction. Auricular contraction not always defined.

and *F*, which give character to any tracing, are apt to be reversed. But this is a matter of little consequence. If, however, the waves *A*, *J*, and *F* are reversed in leads *I* or *II*, the prognosis is regarded by many as grave. Modifications of the above leads are sometimes necessary in

it is both hands; in *II*, right hand and left foot; in *III*, right hand and right foot, and so on. The course of a current is called a "lead." Where no lead is mentioned it may be assumed to be lead *II*.

But of course the strength of the current is modified to some extent by the amount

of superlying flesh, and the best records are taken from spare people.

The electrocardiogram is also subject to variations depending on age, individual character, and the position of the heart. Each individual has a more or less distinct electrogram.

This apparatus should include a couple of hand, arm, or foot baths of metal, zinc being generally used, to which the electric wires are attached, while the hands, arms, or feet are immersed in the salt water of the bathtub. The cost of the whole, as made by Edelmann, of Munich, runs from \$400 to upward of \$1000, and

notch. On the lower line is the record of the time marker. Each abscissa represents $\frac{1}{2}$ second. Owing to the fact that the sensitive paper did not move with uniform speed, the time marking is not absolutely, though nearly, uniform. This is one of the minor errors to which such delicate instruments are liable.

The absence of the auricular notch is apt to be ascribed to some affection around the Keith or Jawara node causing disturbance of transmission.

An effort has been made to construct from a large number of electrograms the tracings of certain well-known forms of

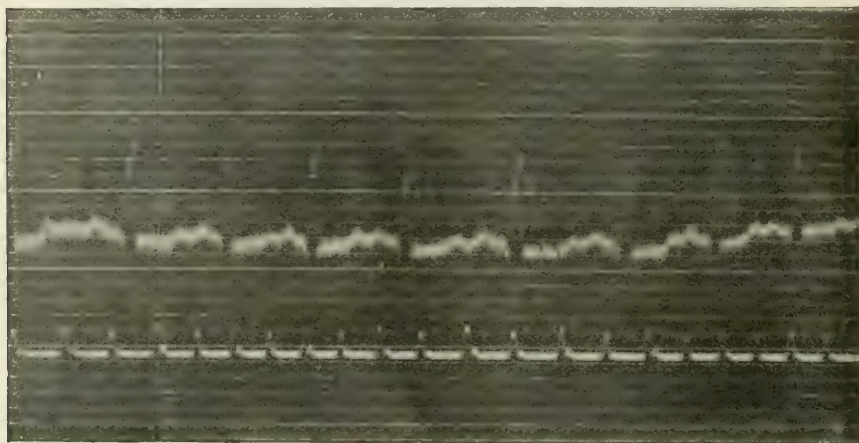


Fig. 26.—Mitral insufficiency. Arrhythmia; irregularity in time and force of ventricular contractions; also in time and force of auricular contractions, but the latter are well marked. Two extra-auricular systoles.

may be much more, especially if duty is paid on it.

Fig. 22 is a scheme made to represent the electrocardiogram of a healthy adult, and the notches or waves are indicated by letters. It is best to take the tracing when the patient is in the reclining, not the sitting, position. It may be said here that this graphic tracing of the auricular contraction is apt to be better than if taken from the veins of the neck by any other registering apparatus. Moreover, these notches are apt to be well shown in cases of arteriosclerosis and in heart block.

In Fig. 25 is seen an extraventricular systole. The diminished contractile force of the ventricle is shown by the comparative shortness of the ventricular

valvular disease, such as mitral stenosis, aortic insufficiency, and mitral insufficiency. The difficulty is not so great with mitral stenosis, which in its developed form has characteristic clinical features, and would naturally, at least when there is the "check" that is associated with the presystolic murmur, give a characteristic tracing. As a matter of fact in well-developed mitral stenosis the auricular wave *A* is apt to be broad, high, and notched. But these lesions are so generally intermixed, *i.e.*, the valvular lesions are so apt to be multiple, that it must be impossible in the vast majority of cases to dissociate them. Indeed, until autopsies have been made in sufficiently large numbers to furnish tracings for individual single lesions we shall not be able to say

this or that curve belongs to this or that valve lesion.

Inasmuch as this presence of a single lesion is so very infrequent, the call for a special curve tracing to diagnosticate a special valve lesion becomes of less importance from a diagnostic point of view.

It is important to control the electrocardiogram by means of other methods of graphic tracing so that one may help to interpret the other. Kraus and Nicolai believe, however, that the electrocardiogram is even now applicable for clinical medicine, although it must be admitted there is still a lack of correspondence be-

mal conditions of heart and lungs will yield normal tracings.

Sometimes there is a sixth notch (see Fig. 23). In children the notches are shorter, and often in persons of powerful build they are higher, but it is not always so. In the *pulsus irregularis perpetuus* the auricular notch is absent.

According to Lewis, galvanometric examinations of the heart give indications of thickening of one or another of the cardiac chambers. They locate small lesions in the cardiac

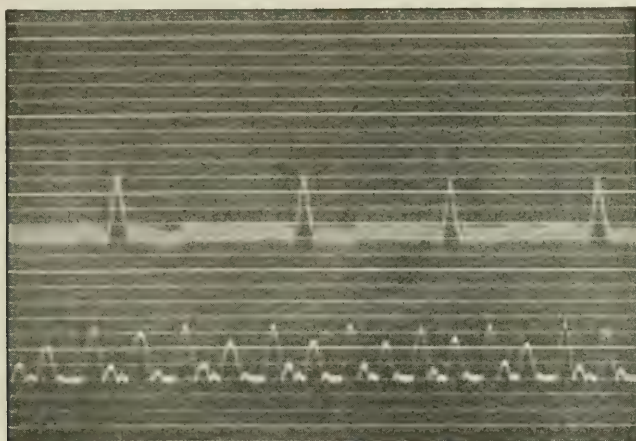


Fig. 27.—General arteriosclerosis with anginal attacks. Showing negative phase following initial ventricular contraction in place of positive phase (inverse type). This is regarded by Kraus and Nicolai as an important sign of beginning arteriosclerosis, and is apt to be associated with cardiac insufficiency. (Franzensbad, July 20, 1910.)

tween physiological and clinical tracings. To their minds, however, a diagnosis in heart cases that embraces chemical, microscopic, and bacteriological methods is not complete without this instrument. Briefly, (1) the electrocardiogram depicts the precise nature of the heart's contractions more completely than any other method; (2) the movements of the auricles are specially well shown; (3) the time and place of the irregularities are also shown, and (4) it augments the means of diagnosis and may be used to control other methods.

And yet, there is really no standard tracing for healthy adults, though in most instances they tally with Einthoven's curve. Occasionally patients with abnor-

mal conditions of heart and lungs will yield normal tracings. They indicate when the impulse originates at the normal center, and, within certain limits, tell where new or heterogenetic impulses originate. They record separately auricular or ventricular contractions, and define the time relation of one to the other. They demonstrate the functional activity of the auriculoventricular bundle, and distinguish slow from fast rates of the pulse. The information relates chiefly to the condition of the heart muscle.

According to my notions, however, this method is not, as yet, taking it

all in all, so valuable for diagnosis as the polygraphic is, or blood-pressure, or X-ray work; it is rather an accessory to other means of diagnosis. Though my personal experience with it has been limited, I have seen enough of it to convince me that it has not yet reached the stage where it is worth while for the ordinary practitioner to depend on it in clinical work. Moreover, it is very complicated, consisting of a number of separate apparatuses, requiring much skill to operate. It is also costly and is very easily put out of condition.

Sensational statements which have appeared in the public journals as to the utility of the instrument must be received with much caution. The electrocardiogram does not as yet of itself distinguish uniformly functional from organic heart diseases. Neither can the use of the instrument dispense with the personal examination of the patient. Hence, a complete diagnosis can not be made by the instrument when the patient and the physician are far apart. Neither the electrographic machine nor any other instrument of so-called precision tells an invariably truthful story. Mechanical difficulties will at times occur, making the picture untruthful. Einthoven has utilized the photographic method of Marey, and the string galvanometer of Ader, while the credit of the completed instrument is due to Edelman. Einthoven has, however, given close study to the method with the perfected instrument, and he is, therefore, entitled, more than any other man, to have electrocardiography associated with his name.

To put it in another way, the instrument is capable of showing the

time and force of action of ventricles and auricles, notes lack of transmission, and demonstrates ventricular and auricular extrasystoles more clearly than any other method. It is certainly useful in various forms of arrhythmias, particularly when there is more or less complete auriculoventricular dissociation. Electrocardiography has already broadened the knowledge obtained by other graphic methods. But at present the initial cost of the Einthoven machine, and the expense connected with operating and maintaining it, will be a bar to its general use, except in the larger hospitals or research laboratories.

THE PHONOSCOPE AND PHONOCARDIOGRAPHY. —

A special method of registering heart sounds and murmurs has been devised by Professors Joachim and Weiss, of Königsberg, in Prussia. It was first described in 1908 (Joachim and Weiss, *Arch. f. Phys.*, 123, pp. 908 and 341; *Deut. Arch. f. klin. Med.*, 98, 1900, s. 513). The sounds and murmurs are registered by photography, and are then reproduced. Last year these experimenters revised their work, publishing their results as applicable to diagnosis in valvular affections.

The sensitive membrane which receives the sounds is composed of a mixture of soapy water and gelatin, prepared as follows: To 1 liter (1 quart) of warm distilled water is added 25 Gm. (6¼ drams) of Marseilles soap. After thorough solution it is cooled, and 660 Gm. (22 ounces) of gelatin are added. This is again cooled down and filtered until the solution is quite clear. It can then be kept indefinitely without change in closed vessels. This preparation is used as a sensitive membrane to receive the sounds in the phonoscope, and it is claimed that this saponaceous membrane surpasses the

most delicate microphone in sensitive qualities as a receiver.

As a medium for conveying the oscillations of the membrane there is a silvered glass filament, bent at an angle, planted in the center of the membrane. The oscillations of the rod are photographed by a registering photographic apparatus, actuated by clockwork, and similar to the machine used in the Einthoven cardiographic machine. The membrane and glass lever are fitted into a case called a phonoscope. This is a small metal box resting on a vertical support, provided with 3 adjustable feet. In one side is a glass window, having a diameter of about $1\frac{1}{4}$ inches. On another wall there is a shutter, in the middle of which is a tube, into which is fitted a socket provided with a circular opening over which the soapy membrane is drawn. The glass lever is attached to the top of the box by shellac, while the opposite end, forming a loop, is planted in the soapy membrane. The sliding shutter enables the operator to move the lever into the required position.

The glass filament is illuminated by an objective in the tube, while another objective projects the image of the filament on the sensitive paper. A telephone siren is then introduced in a telephone circuit, and the ear hears the sound in the telephone receiver.

This is an improvement on the apparatus of Huerthle (Arch. f. Phys., Bd. 60, s. 263, 1895), Donders, and others. Huerthle's method was to place a stethoscope over the site of the apex beat; on the opposite end of this instrument was a resonator made of a hollow wooden cone, in the apex of which was screwed a wooden rod. This latter was the carrier of 24 thin plates of wood to increase the resonance, while on the end of the wooden rod was a wooden tuning fork. Between the branches of this was a microphone, the contact being made by means of opposing armatures of silver and carbon. By connecting this instrument with the

telephone the heart sounds were conveyed to the listener.

ARRHYTHMIAS, CARDIAC.

The subject of cardiac arrhythmias took on a new phase as soon as graphic methods were used for their differentiation. Indeed, the use of graphic instruments has revolutionized the matter by disclosing new data of great practical value. Most of these discoveries have been the work of the last ten years. As a single illustration of the lines of investigation and their clinical results, Friberger (Upsala Laek. Förhand., Jour. Amer. Med. Assoc., March 16, 1912) recently undertook to examine the hearts of 321 unselected children between the ages of 5 and 14, taking graphic records of each child. Only about 37 per cent. had regular pulses. Of the remainder about 12 per cent. had great irregularity and about 50 per cent. a moderate amount. The variety of irregularity was that which Mackenzie has called "the youthful type," and was about equally common in the two sexes. The etiology was not clearly evident, but Friberger found that in advanced tuberculosis there was arrhythmia in about half of those examined. This is only one of the many fields in which graphic methods are helping the practising physician.

It has now been generally accepted that arrhythmias may be satisfactorily classified with reference to the five physiological attributes of heart muscle, demonstrated by Gaskell, in 1882. These are, as is now well known: (1) Rhythmicity, *i.e.*, the faculty of rhythmically initiating a stimulus. (2) Irritability or excitability, *i.e.*, the capacity for receiving

a stimulus. (3) Contractility, *i.e.*, the faculty of responding to a stimulus. (4) Conductivity, *i.e.*, the ability to convey a stimulus. (5) Tonicity, *i.e.*, the power to maintain cardiac tone.

Four distinct varieties of arrhythmias corresponding to the first four faculties or attributes can be demonstrated by graphic tracings.

To the first of the forms to be described I have given the name **pneumogastric arrhythmia**, because of its close relation to pneumogastric influences. It was described by Kussmaul years ago, and has been called vagus, fundamental, sinus, normal, or respiratory arrhythmia. The word sinus implies that it is a variety of the rhythm that originates in the sinus venosus, *i.e.*, it is the normal rhythm. This pneumogastric arrhythmia is a variation from the standard cycle within physiological bounds. Though the cardiac cycle varies in length, the systolic phase is little altered comparatively, while the diastolic is considerably lengthened, and this latter feature is the chief characteristic.

It may be seen in a tracing of the radial pulse immediately after the apneic period of the Cheyne-Stokes respiration of uremia. Kussmaul called it the **pulsus paradoxus**. It is the pulse following a deep inspiration; hence the term "respiratory." It can also be caused by the act of swallowing, which is largely regulated by the vagus or pneumogastric; hence the term pneumogastric arrhythmia. Apart from graphic tracings, this form of arrhythmia is recognized by the finger on the pulse. It can usually be inhibited by one dose of atropine, $\frac{1}{60}$ grain (0.001 Gm.).

It is not well to attribute too much importance to an arrhythmia which is usually quite transient, functional in character, coming and going from slight causes. But exceptionally it may be of a more serious nature, as in tuberculosis, or after infective diseases, especially the eruptive fevers of children. It occurs sometimes in neurasthenia; also in overdosing by digitalis and probably other drugs which affect the cardiovascular mechanism. From whatever cause, it is a loss of the normal rhythm, the stimulus to which we believe originates, as I have said, in the sinus venosus.

In **extrasystolic arrhythmia** there are extra—that is, as it were, supernumerary—contractions, from stimuli that do not originate in the sinus, though in the main the regular or sinus rhythm is maintained. They are of two principal types: the *ventricular*, where the contraction originates in the ventricle, and the *auricular*, where it originates in the auricle. Take an example of what appears to happen in these cases. If for any cause the left ventricle fails to empty itself, the residual blood, acting as a stimulus, can make the ventricle put in an extra beat before the normal auricular stimulus has passed down to it. On the other hand, in dilatation of the auricle, as, for example, in advanced mitral stenosis, the incomplete expulsion of the blood into the ventricle may operate to produce a supplementary contraction, which would then be an auricular extrasystole. Strain of auricle or ventricle also might, and probably does, produce extrasystoles. These have been called "dwarf" systoles, from their small size; "pre-mature" systoles, because the contrac-

tion is in advance of the normal period for the contraction, and "interpolated" systoles, because they are actually interposed between beats that are of the prevailing type at the time.

All extrasystoles are followed by a pulse period that is rather longer than the normal. In the ventricular form the length of the preceding pulse period added to that of the following pulse period is equal to the length of two normal pulse periods. In the auricular form the pulse period following the extrasystole is shorter than the corresponding compensatory pause in the ventricular form. Such systoles occur at regular or irregular intervals. They are illustrations of an abnormal irritability or excitability of the heart, and are most common in persons of a neurotic constitution. Sometimes these extrasystoles cannot be detected by the finger, but they are usually recognized upon auscultation, when the regular sequence of beats is occasionally interrupted by one or two short sounds followed by a brief pause.

When, in a radiogram (radial pulse tracing), it is noted that the length of the pulse period preceding the extrasystole, together with the pulse period following, constitutes a length of two ordinary pulse periods, this is taken to mean that the extrasystole is ventricular, and, according to Mackenzie, that the stimulus originated in the His bundle, on the distal side of the node. But the points of origin of the stimuli may be in other parts of the tissue intermediate between auricle and ventricle. These matters are still engaging the attention of physiologists, and have not been absolutely determined.

In the auricular extrasystole the stimulation is thought to arise in the primitive tissue of the auricle. These extrasystoles can be seen in jugular tracings. A characteristic of this auricular extrasystole is that in the arteriogram the compensatory pause following is shorter than in the ventricular extrasystole, as already stated.

Extrasystoles occur under the most varying conditions. Coffee, tea, tobacco, and gastrointestinal distention are examples of determining causes; under these circumstances their occurrence may not be of very serious importance, though when they happen in toxemia, in convalescence, or in the weak heart their presence adds to the gravity of the situation. They may occur in conjunction with other cardiac manifestations, when they constitute a further complication.

Not infrequently the extrasystole is appreciable by the patient, who may feel a sudden thud in the precordium, perhaps with a sense of faintness. It may even seem as if the heart were going to stop, and, as a matter of fact, it may actually do so. I have had such a case, where the heart did stop for several seconds—how many I do not know. It may be remembered that a man named Nordini, an Austrian Pole, is said to have the power of stopping his heart for twenty seconds, and his statement has not, I think, been contradicted. But the extrasystoles are not always appreciable subjectively. To make them distinct, the patient should be told to run round the room a few times and then hold his breath. The extrasystoles are intensified by hurried movements.

The really most important function

of heart muscle is contractility. A striking example of its abnormal characteristics is seen in the **alternating pulse**, which consists of an alternation of large and small beats. The alternation is continuous,—which distinguishes this type of pulse from extrasystolic arrhythmias. It may always be recognized and differentiated by graphic methods when other physical methods leave doubt as to the diagnosis. It is, however, a rarity.

Another example of abnormal contractility is seen in **auricular fibrillation**, formerly called **nodal rhythm** by Mackenzie, and one cause of the **permanently irregular pulse** of Hering. Here the cardiac cycles vary so much that there is no sequence of beats having the same length. This special characteristic was well shown in one of my cases of heart block. The source of the difficulty is put at the auriculoventricular node, which governs auricular and ventricular contractions through the bundle of His.

In 1905 Cushny and Edmunds suggested that in some of these patients the cause might be auricular fibrillation, a condition in which component parts of the muscle wall of the auricle contract independently of one another, and in such a disorderly fashion that it might almost be said auricular contraction as a whole was at a standstill. But it was not until 1909 that researches by Lewis on the lower animals showed, by comparison of the arterial and venous pulse tracings and electrocardiograms, that this so-called nodal rhythm, or permanently irregular pulse, was to be attributed to auricular fibrillation.

In fibrillation there seems to arise in the auricle a continuous shower of

stimuli, which, falling on the node, excite it to send stimuli to the ventricle as rapidly as the bundle (and so the ventricle) is capable of taking them up. At first the ventricular contraction is apt to be very rapid, and the patient may die rapidly of heart-failure. But if the ventricle can be made to beat more slowly, the patient may lead a useful and even vigorous life for some years. It is therefore very important to diminish the rate, and this is done in a remarkable manner by digitalis. The gravest sign is an increase in rate; say, from 100 to 150. The digitalis should then be pushed until there is a fall to 80. My experience tallies with Lewis's view; for in the permanently irregular pulse, relief only comes from the continuous use of **digitalis** or **strophanthus**. Hering recognizes this fact. Mackenzie believes, however, that a good deal can be done for the patient. He finds, for example, that the irregularity is most often associated with rheumatic hearts, usually those of mitral stenosis, and with the fibroid heart of senility. In fact, as the deposit of fibroid tissue is common in both these varieties of cardiac disease, it seems possible that the fibroid deposit is the cause. In one case of mine there was a fibroid tumor of the uterus, but its removal did not improve the cardiac difficulty.

According to Lewis, auricular fibrillation constitutes at least 50 per cent. of all irregularities, the disturbance of cardiac rhythm having its origin in the auricle, and being due to temporary or permanent incoordination of the musculature of this chamber. In a study of 106 cases he has reached the following conclusions, which differ somewhat from

those of Mackenzie: The rate of the pulse may be reduced as low as 30, or increased as high as 200, but this in itself has little significance, because many beats of the heart may not reach the radial artery. The high rates, however, between 110 and 150, are the most common, and with these the irregularity is greatest. According to Lewis, the diagnosis rests on these points: 1. The absence of the normal auricular contraction, as seen by the absence of the wave in the tracing. 2. The presence of a ventricular beat having its origin in an impulse received from the auricle. 3. Special oscillations in the curve, which have been shown to be due to the continual contraction of the various parts of the auricle quite without system or co-ordination. 4. Constancy of this picture from patient to patient in respect to the first three points.

Fibrillation is responsible for most of the disturbances of the ventricular system. Indeed, in the vast majority of instances a sphygmogram showing that no two successive heart beats are of the same length implies the diagnosis of auricular fibrillation. To Cushny, Mackenzie, Wenckebach, Rothberger, Winterberg, and Lewis the credit of the discovery is due. Janowski has known such a case to last five and a half years; Mackenzie, ten years; I, upward of twelve years. Auricular fibrillation is also clearly shown in an electrocardiogram, but when the pulse is naturally infrequent or when the rate has been slowed by digitalis. Of the existence of auricular fibrillation there can be no doubt.

Lewis ("Mechanism of the Heart Beat," London, 1911) has been able

to demonstrate, by the use of the electrocardiograph in association with the myograph, that there may be ventricular as well as auricular fibrillation. In an experiment on a dog he tied the descending branch of the left coronary artery, and also obstructed the blood flow in the right coronary. The result in both cases was to cause premature ventricular contractions, producing increased frequency of the pulse, the rate rising to 300 and upward, while eventually *delirium cordis* ensued. In subsequent experiments ventricular fibrillation was induced by irritating a papillary muscle, the central surface of the right ventricle, or its lower angle. But ordinarily the normal pulse rate returned, on removing the obstruction or suspending the irritation.

Chloroform anesthesia was also found to produce ventricular fibrillation in cats (Lewis and Levy), followed by heart-failure. Intravenous injection of adrenalin chloride, in doses of from $\frac{1}{4}$ to 1 minim (0.015 to 0.06 c.c.) of a 1:1000 solution, had the same result, if the anesthesia was light, and there was seldom recovery. But administration of the same amount of adrenalin chloride under deep anesthesia was less dangerous.

Ventricular fibrillation may be demonstrated by the electrocardiograph, as reported by Hofmann ("Heart," vol. iii, 1911-12). His patient had "paroxysmal tachycardia," but recovered eventually.

In affections of conductivity the normal stimulus, which starts in the sinus venosus, passes from the primitive tissue of the auricle over the bridge of His to the ventricle, may be delayed in its course, may not

cross at all, or may be arrested beyond the bridge. Any one of these several conditions will produce **heart block**, a term invented by Gaskell, in 1882, to indicate arrest or blocking of the impulse normally conducted from auricle to ventricle.

The **infrequent pulse**, improperly called the slow pulse, is very apt to indicate a loss of conductivity. When, as happens in such cases, a pulse is found where only about 26 to 40 beats can be recognized at the wrist, an inspection of the jugular will usually show that the auricular

independently of the ventricle. Where there is complete heart block, the a-c intervals may be seen to vary so that no two have the same length. Manges (*Med. Rec.*, April 8, 1911) has recently given the history of a patient with incomplete and subsequently complete heart block, in whom the auricular rate, as shown by graphic tracings, was 280 to the minute, the ventricular ranging from 40 to 70, which rate, however, was raised to 120 on two occasions by the use of atropine.

Among the most frequent causes

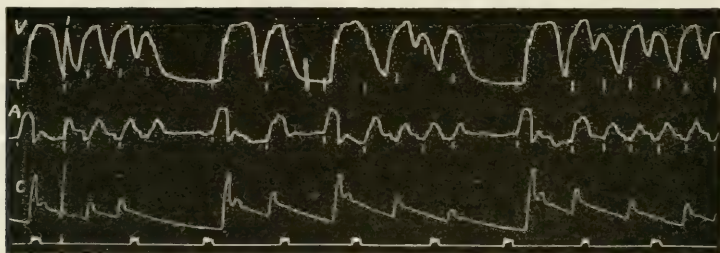


Fig. 23.—Myocardiographic curves (V, ventricle; A, auricle) and carotid pressure curve (C) by the Huerthle instrument from a dog in which the right coronary had been tied. The events are those which occurred directly before the onset of a long paroxysm of tachycardia, the commencement of which is seen in the last six beats of the figure. The earlier portions of the figure show runs of premature ventricular contractions (most of which retrogress to the auricle) with occasional breaking back to the normal rhythm at the end of the long pauses. Briefly, there are short preliminary paroxysms before the final long paroxysm is established. Abscissæ, 1.43 and 1.49 seconds. (Modified from *Lewis*.)

contractions are really twice or even more times as frequent. This inspection should always be made, when, if the head is turned to the left, the beating of the vein can be seen in a good light, and the diagnosis made without the aid of graphic methods.

In health the a-c intervals show in tracings the time occupied by the passage of the blood from the auricle to the carotid, which is usually one-fifth of a second, though it may be two-fifths, and persist at that rate for years. In complete heart block the a-c interval varies so much that the auricle may be said to beat quite in-

dependently of the ventricle. Where there is complete heart block, the a-c intervals may be seen to vary so that no two have the same length. Manges (*Med. Rec.*, April 8, 1911) has recently given the history of a patient with incomplete and subsequently complete heart block, in whom the auricular rate, as shown by graphic tracings, was 280 to the minute, the ventricular ranging from 40 to 70, which rate, however, was raised to 120 on two occasions by the use of atropine.

Among the most frequent causes of loss of conductivity are syphilis, fibrosis, and neoplasms. Since the cause of auricular fibrillation is sometimes the same as that of heart block, though usually located in the substance of the ventricle, the one may pass over into the other. The condition may also be due, and in several of my cases has been, to hemorrhage at the base of the brain, when pressure is brought to bear on the nucleus of the pneumogastric. Stimulation of the peripheral branches of the pneumogastric may also produce heart block; likewise, aconite, epinephrin, muscarine, physostigmine,

and asphyxia. In a case of acute heart block, recently reported to me by Waitzfelder, of New York City, the condition was evidently due to overdosing by digitalis.

According to Mackenzie, the stimulus may go through and the pulse be as high as 70, and then fail to go through, leaving the pulse at 30. Such cases should encourage us to use appropriate remedies to restore the heart's action. Certainly if there is the slightest suspicion of advanced syphilis, antisyphilitic remedies should be pushed to the limit.

It is important to know that a diagnosis in heart block can be made without the use of graphic methods.

THE FREQUENT PULSE.

The *frequent pulse*, like palpitation, is not a disease, but a symptom. It may be physiological or pathological. If merely the accompaniment of, or sequel to, violent exertion, in which the heart is called on for increased energy, within normal bounds, the frequent pulse is physiological. But from whatever cause, so far as we know at present, increased frequency must be laid to nervous influences.

Experiments on animals show that irritation of the accelerator nerves increases the pulse-rate. Similarly, section of the pneumogastric, or injury to its nucleus, increases the pulse rate to 150 a minute or over. It produces the continuously frequent pulse. On the other hand, pressure on the pneumogastric will, in some persons, arrest a frequent pulse. Curiously, according to Martius's experiments, when an injury to the pneumogastric causes a frequent pulse, the rhythm is always normal unless affected by reflex influences.

However, according to the experience of Hoffmann, in cases of paroxysmally frequent pulse with abrupt onset, sudden ending, and arrhythmia, the cause may be the *interpolation of beats*. This matter is considered under the head of auriculo-ventricular fibrillation.

To appreciate the situation better, it may be well to review some of the points bearing on the nerve supply of the heart. First of all, there are three sets of nerves that influence the heart: (1) The pneumogastric slows it and lowers arterial pressure. (2) The sympathetic supplies the accelerator, quickens the action of the heart, and also furnishes nerves that regulate the caliber of the arteries (Mackenzie). (3) The ganglia are the intrinsic nerves of the heart, controlling its systole and contractions. The investigations of von Bezold and Martius show that abstraction of the influence of the pneumogastric permits of an increase of the heart beats of only from 120 to 180, while irritation of the sympathetic permits of an increase of beats to 120. The action of the ganglia in affecting the heart rate is considered in another place.

While these experiments explain how in lesions of the pneumogastric or its roots the pulse may reach 150 to 180, they fail to explain higher rates except by the supposition that the combinations of disturbed action of the cranial and the sympathetic nerves and ganglia may increase the rate beyond 180, and they also fail to explain the cause of the frequent pulse when there are no nerve lesions manifest.

The full list of causes, as given by Larcena, is as follows:—

1. *Tachycardia in diseases of the heart and blood-vessels.* Under this head is included the increased action of the heart which occurs in overstrain, acute and chronic myocarditis, valvular diseases, pericarditis, angina pectoris, acute and chronic aortitis, arteriosclerosis, and the affections of the heart that occur in Bright's disease.

2. *Febrile tachycardia.*

3. *Tachycardia from peripheral compression*,—that is, on one or both trunks of the vagus,—and from central compression of its nucleus.

4. *Tachycardia from organic disease of the nervous system.*

5. *Tachycardia in general diseases:* (a) Acute diseases, such as typhoid fever, diphtheria; (b) chronic diseases, such as tuberculosis, carcinoma, chlorosis, syphilis, chronic malaria, chronic rheumatism of the joints; (c) convalescence and exhaustion.

6. *Tachycardia* (a) from alcohol, coffee, or tea, and (b) from drugs, such as digitalis, atropine, etc.

7. *Reflex tachycardia* from the brain, heart, lungs, stomach, liver, intestines, uterus, abdomen, bladder, prostate gland, brachial plexus.

8. *Tachycardia in neuroses:* Graves's disease, hysteria, neurasthenia, epilepsy.

To which must be added:—

9. *Tachycardia* from irritation of the substance of the heart and its ganglia, or occlusion, partial or complete, of the coronary arteries.

There are three forms of the frequent pulse: the *temporary*, the *paroxysmal*, and the *permanent*. An example of the temporary is the frequent pulse resulting from any violent exertion. Examples of the paroxysmal form are seen in neuras-

thenic states, in which there is a sudden frequency of the pulse and a sudden decline, lasting hours, days, weeks, or months, and often leaving the patient exhausted and sometimes with a dilated heart. The permanent form is frequently seen in chronic tuberculosis, in which there may be no considerable rise of temperature, or in tertiary syphilis with pulmonary complications. This latter form of frequent pulse continues to the end of life.

In the paroxysmal varieties the pulse is usually small and compressible, due probably to imperfect filling of the vessels. In 30 cases given by Martius it ranged from 80 to 180, the average being from 120 to 140. The pulse frequently, however, may reach 300 and more. Bristowe has recorded a pulse of 308, but this is very exceptional. Such pulses can only be counted by some instrument of precision.

The frequent pulse may occur in childhood, middle age, or advanced years. Broadbent has recorded a case at 10 years of age and another at 81.

In the paroxysmally frequent pulse the symptoms vary. Almost all of the patients are anxious and complain of lassitude. There is often precordial oppression. Some patients are cyanotic, others are not. Some attend to business as usual. The lungs are usually free. Among German writers, such as Riegel and Martius, there have been noted instances of pulmonary emphysema, which appeared with the frequent pulse and disappeared with it. Martius gives 3 cases. It is well, however, to keep in mind that in Germany clinicians are apt to rely on a low position of

the liver in their diagnosis of emphysema, a sign that elsewhere is not regarded as of so much importance.

In 8 of Martius's cases there was cardiac dilatation, which was a sign that the cases were severe. Among other signs that have been noted are venous thromboses, swelling and pulsation of the veins of the neck, albuminuria, and edema.

There is much to learn in the matter of treatment. As, however, pressure on the pneumogastric nerve will reduce pulse frequency, it has been tried and with temporary success. **Iced water** and **strong coffee** have sometimes been effective; so have **Hoffmann's anodyne** and **diffusible and alcoholic stimulants**. Dr. W. H. Thomson, of New York, in a record of 6 cases of tachycardia associated with various forms of neurasthenia, ascribes the disease to gastrointestinal intoxication, and reports success under the use of the salicylates, especially **strontium salicylate** in 15-grain (1 Gm.) doses, weak **mercurials**, **intestinal antiseptics**, and a carefully regulated **diet**, which excluded highly nitrogenous food. On the other hand, when the frequent pulse is reflex, so that we can ascribe it to non-toxic diseases of the stomach, kidneys, ovaries, uterus, or other organ of the abdominal or pelvic cavity, it may be due to arterial hypertension (Huchard), or to vasomotor paresis. Clement and Hirsch attribute the pulse to mere excitement of the nervous system. In the permanently afebrile frequent pulse it may be impossible to reduce the pulse rate materially; but we must always keep in mind that it is merely a symptom and not necessarily a distressing one. Nor should we attempt by the use of

drugs, such as hellebore, digitalis, and the like, to reduce cardiac frequency, for in so doing we only increase personal discomfort without accomplishing any useful purpose. If, however, the constitutional affection, be it tuberculosis, syphilis, or any exhausting disease, improves, the pulse will fall at a rate corresponding to the improvement. It is the general condition of the patient, therefore, for which we should be solicitous, rather than his pulse. A rate of 120 to 130 does not necessarily produce distress, and it may not be inconsistent with a fairly active life.

Abdominal compression may be successful in some cases. Dr. W. Gordon (Brit. Med. Jour., March 10, 1910) has reported the case of a man 68 years of age who was thrown down by a motor car. He developed "paroxysmal tachycardia" from the accident, combined with a flatulent indigestion. The pulse rate was 180. A stout **flannel binder** was tightly applied over the abdomen. The pulse then assumed the normal rate. Thirty-seven days later, the tachycardia again appeared, after which the binder was again applied, the pulse again assuming the ordinary rate. It became stronger, and was free from intermissions.

The prognosis, as a rule, is unfavorable in the recurrent cases, but a man may possibly live with it to the age of 81 years, and recovery has taken place from a pulse rate of 260.

THE INFREQUENT PULSE.

The words bradycardia (introduced by Grob), spanocardia, araiocardia, and oligocardia (kardios, heart; brados, slow; spanos, deficient; araios, rare; oligos, few), that have

been applied to the infrequent pulse, are misleading. The use of the termination *cardia* implies that clinically the key to the action of the arterial current is to be found in the heart, rather than in the peripheral arteries. And yet a comparison between the readings of recording instruments that register the heart and pulse beats simultaneously illustrates that there may be a wide variation in frequency and rhythm between the two.

For example, a double contraction at the left ventricle may be registered in a sphygmogram as a single one, while a cardiogram will show cardiac contractions of which there are no traces in the sphygmogram. This latter circumstance, of the "intermittent pulse" (as distinguished from the "deficient pulse," where both cardiac contraction and the pulse beat are simultaneously "missed"), is, of course, very common. Now, though the left heart regulates the general circulation, its essential characteristics are better exhibited at the periphery than at the center. And for two reasons. The peripheral arteries are more accessible, and therefore may be more conveniently studied than the heart, and they give us more information because cardiac action is better appreciated at a distance than near by. It is not uncommon to judge of motive forces by their remote effects. In telegraphing or telephoning, the one who transmits the message cannot judge of the quality of his instrument and medium of transmission so well as the one who receives it. Clinically, therefore, the circulation is better estimated by the pulse than by the heart. So that there is a reasonable objection to the

use of all terms ending in *cardia*. But apart from this, the qualifying prefixes are either improper as in the use of *brady*, or are vague in meaning. *Bradycardia* implies that the ventricular contraction is prolonged beyond the usual time; in other words, that it is slow; but so far as I know, slow ventricular contraction occurs only in aortic stenosis or in aneurisms near the aortic orifice, where some obstruction like an atheromatous plate diminishes the lumen of the vessels, the contraction of the left ventricle being necessarily prolonged, in order to permit it to force the column of blood through the constricted passage.

But this is not the common acceptance of the term, which is simply that the number of pulse beats to the minute is abnormally small. As a matter of fact, however, pulse beats, in the infrequent pulse, may be quick or slow.

To my mind, of all the terms suggested no one expresses this numerical deficiency so well as the term, *the infrequent pulse*.

The pulse rate, as is well known, varies more or less according to circumstances, such as the age and height of the individual, atmospheric temperature, the time of day, and acquired or inherited peculiarities. In the adult male the standard is set at 72; in the adult female at 76 to 80. Large individuals have a slower rate than small ones, and, while the average rate at birth is set at 140, it falls gradually toward 70 in senility, rising again gradually toward 80 in extreme old age. Also, as blood-pressure in the arteries falls, the pulse rate rises, while as the pressure increases the rate falls. In some

alterations of the blood, as in asphyxia, where the CO_2 content rises, the pulse rate first increases and then decreases as soon as toxic symptoms supervene (Howell). These facts should always be borne in mind in estimating the significance of a high or low pulse rate. And yet it is by no means rare for a person in apparently good health to have a pulse anywhere in the sixties. By general consent, however, a pulse below 60 is to be regarded as an infrequent pulse.

The infrequent pulse may occur at almost any period of life. Prentiss (*Trans. Amer. Phys.*, p. 120, 1889) has reported 1 instance at 16 months. It was caused by an injury to the neck, followed by an abscess between the medulla and pons.

Grob says it may occur as late as 90, usually, however, between 20 and 40. In my experience it is more often seen in the middle period of life or after it.

The infrequent pulse in adults (where the rate falls below 40) is rare, though most practitioners with large experience have probably seen occasional instances at some time or other in their practice. If, however, we should adopt 60 as the figure below which all pulses are to be reckoned as infrequent, we would find them comparatively common. According to Grob's (82 in 3578 patients, *Deut. Archiv f. klin. Med.*, Bd. xlii, S. 5574, 1888) experience, about 1 individual in 40 has an infrequent pulse. It is unfortunate, however, that observers have often failed to note the relation in number per minute between the pulse and the heart beats, though the importance of ascertaining this variation was

pointed out by Stokes ("On the Heart," etc., p. 329, 1855), in 1846, when he told of a patient whose heart beats were 36 to the minute, while the pulse was 28.

Four different relations between the arterial and venous activities and the heart are important to note at this point: (1) The heart and pulse may beat simultaneously. (2) The heart beats may not all be communicated to the extremities. (3) The auricles may pulsate more frequently than the ventricles and arteries. (4) Contractions of the several chambers may occur independently or even simultaneously.

The first two of these statements have been satisfactorily proved by clinical experience; the last two by physiological experimentation, where electrical currents and other stimuli have caused muscular contractions after death.

The infrequent pulse has two principal varieties, the physiological and the pathological.

Of the first we have two well-known instances, the infrequent pulse of inheritance and the pulse of pregnancy.

Prentiss (*Trans. Amer. Phys.*, p. 120, 1889) has recorded several instances where persons whose pulses averaged 30 to 32 were in apparently sound health, and historians tell us not only that Napoleon's pulse was 40 even in the midst of a battle, but that he felt uncomfortable when it rose to 60. The most remarkable instance, however, is, I think, that of Vigouroux (*Gaz. des Hôpitaux*, 876, p. 788), who had under his observation a laborer whose pulse never exceeded 20. The man never experienced any illness so far as he knew,

except on one occasion, when he had a short and slight gastric attack that was successfully treated. In this connection it is interesting to remember that Czermak (*Viertel Jahressch. f. pract. Heilkunde*, 1868, p. 190) could stop the action of his heart for a few beats by pressure on the pneumogastric, and Quinke (*Berlin. klin. Woch.*, No. 15, p. 190, 1875) has verified this experiment.

The infrequent pulse is more common in males than in females, the ratio being about 5 to 1, according to Prentiss's tables.

Of the pathological we have two subdivisions, the paroxysmal, periodic, or temporary, and the chronic or essential. Under the causes of the former come infections, such as typhoid, diphtheria, pneumonia, erysipelas, puerperal infections, and influenza (best seen during convalescence); in toxemias from lead, tobacco, tea, coffee, digitalis, uremia, cholesteremia, and syphilis; in functional nervous disturbances, reflex influences from the skin or gastrointestinal tract, and in temporary debility.

Under the pathological variety come also organic diseases of the brain or cord, or of the heart itself. According to Prentiss, the infrequent pulse is chiefly due to organic disease of the brain or cord, epilepsy, and organic heart affections, though in 89 of his cases the cause was stated to be unknown in 35.

The paroxysmally infrequent pulse, according to Grob, represented 112 out of 140 of his cases. His experience that the paroxysmally infrequent pulse largely predominates coincides with my own. Under pathological conditions the pulse rate

is subject to wide variations in range, while, as we have seen, under physiological conditions, it maintains a tolerably steady rate. In the first-named condition very low rates have been recorded. Holbertson (*Medico-chir. Trans.*, vol. xxiv, p. 76) has published one instance where the pulse fell on one occasion to $7\frac{1}{2}$ in a patient who had attacks of vertigo and loss of consciousness following an accident on the hunting field. At the post-mortem examination it was found that there had been pressure on the medulla and upper part of the cord, the result of fracture of the occipital bone and upper cervical vertebræ. Bony union of the parts had ensued, but with displacement of the fragments. Other instances have been published where the pulse fell as low as to 4 (W. Henry Day, *Brit. Med. Jour.*, vol. i, p. 113, 1880; the pulse beat four times a minute for about four minutes during an attack of unconsciousness) and even 3 (Prentiss, in case 79). This last case was one of the paroxysmal variety, and the patient rallied from the attack.

The etiology of the infrequent pulse is not altogether clear. We can readily realize that pressure on the pneumogastric may cause it, as in Czermak's and Quinke's experience, and there are many instances where there was organic diseases at the base of the brain from pressure by bone, as in Holbertson's case. Moreover, much light has been thrown on this subject by recent discoveries, and particularly by that of the auriculo-ventricular or His bundle, or Gaskell's bridge.

To summarize, it has long been known that at an early period in

embryonic life the heart is a tube, at one end of which is the sinus venosus, where the venous trunks unite (Fig. 29). From this tube pouches develop, to become, on the one hand, an auricle (*B*) and, on the other, a ventricle (*A*), while the original tube, the auricular canal, still connects them. Later, in connection with the

not so in the human species. The remains of this sinus, however, were discovered by Keith and Flack (*Jour. of Anat. and Phys.*, vol. xli, pp. 172-189), in 1897, and located at the mouths of the venæ cavæ. Previously, Keith, *His* (*Deut. Archiv f. klin. Med.*, vol. lxiv, p. 316), and others had found the primitive tube (which

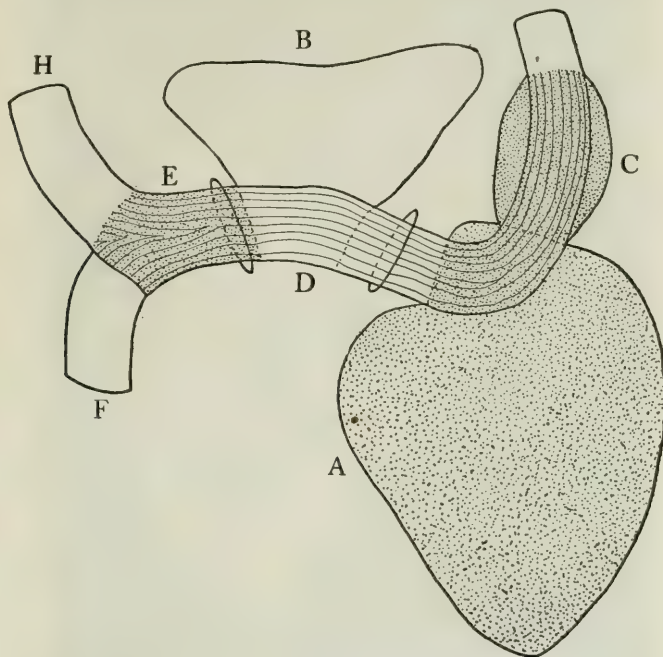


Fig. 29.—*D* is the primitive mammalian tube, indicated by longitudinal striations, extending from the sinus venosus (*E*), where the upper vena cava (*H*) and the lower vena cava (*F*) join, through the bulbus cordis (*C*) to the aorta. *B* is the primitive auricle and *D* the auricular portion of the primitive tube, or auricular canal. *A* is the ventricle. The bulbus cordis is eventually included in the human right ventricle. (Schematic representation after *Keith*.)

sinus are formed the superior vena cava (*H*) and the inferior vena cava (*F*), a portion of the right auricle, and the coronary sinus. Eventually this primitive tube is converted into the His bundle, known to some as Gaskell's bridge, or auriculoventricular bundle, which unites auricle with ventricle. In the lower vertebrates the sinus venosus, auricular canal, and aortic bulb are still recognizable, but

eventually becomes the bundle) extending over from auricle to ventricle. The node was first called, from its discoverer, Tawara's node ("Das Reizleitungssystem," Jena, 1908). It is situated in the wall of the right ventricle, near the mouth of the coronary sinus. Tawara, Keith, and Flack were able to trace the auriculoventricular bundle to the auriculoventricular septum, from which its

branches extend into the walls of the ventricles.

The bundle curves over to the membranous septum, entering and following the moderator band (*F*), until it reaches the base of the large group of papillary muscles (*G*). This

Tigerstedt, Gaskell, Kent, His, Retzer, Braeunig, and Tawara has proved that round about the coronary sinus and at the base of the septum there is a specialized group of auricular fibers now known as the auriculo-ventricular or Tawara's node. From

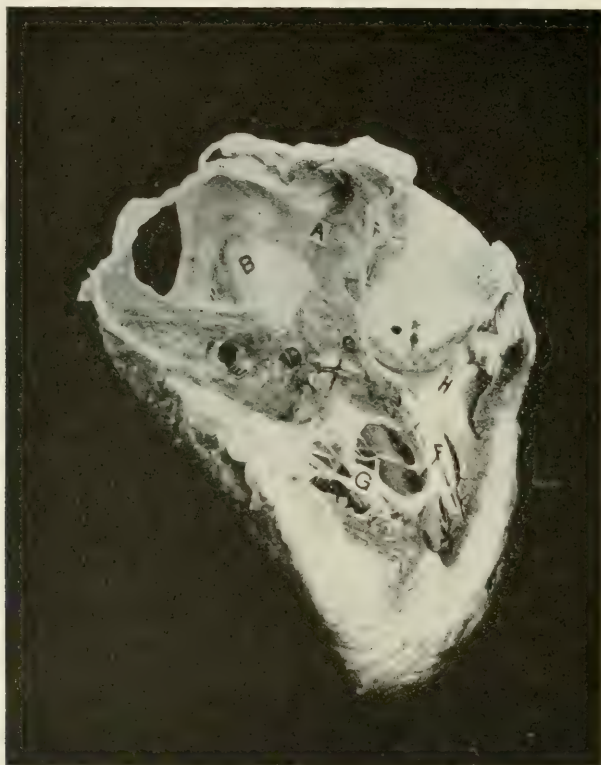


Fig. 30.—Human heart, showing the origin, course, and distribution of the auriculoventricular (His) bundle. The anterior walls of the right ventricle and right auricle have been removed. The intra-auricular septum, the tricuspid valve, the papillary muscles (*G*), the moderator band (*F*), and the interior of the infundibulum (*H*) are exposed. *A* lies in the right auricular appendix, *B* in the fossa ovalis; *E* is placed beneath the mouth of the coronary sinus. Directly beneath *D* is a fan-shaped bit of muscle; a bristle has been placed beneath it. From this point the auriculoventricular bundle and its right branch are traced as they lie on five bristles between *D* and *F*. From a specimen in the possession of Keith. (Lewis, "Mechanism of the Heart Beat," London, 1911.)

bundle of muscle-tissue connects auricle and ventricle functionally, the impulse originating in the auricle and passing gradually into the right and left groups of papillary muscles (Fig. 30).

Briefly, the work of Wooldridge,

this point the bundle runs at first almost horizontally forward and to the left, ensheathed in a fibrous canal, and it pursues its course directly to the right of the central fibrous body of the heart, as far as to the membranous part of the septum of the

ventricle. At the anterior part of this membrane the bundle divides, entering the left ventricle immediately beneath the center of the aortic valve. Ultimately its branches are continuous with the subendocardial network of Purkinje's fibers, which lines most of the interior of both ventricles.

The bundle thus constitutes the functional union between the auricle and ventricle, and it is through this structure that normally the impulse from the auricle originates and causes ventricular contraction. But the structure of the various divisions of this system varies considerably. At the auriculonodal junction the fibers are those of smooth muscle tissue, interspersed with connective tissue, nerve fibers, and ganglion cells. In their course the muscle fibers increase in size until they form networks, and finally take on the well-known character of Purkinje's fibers.

There are also probably accelerator and inhibitory ganglia in the sinus venosus and auricles, as they have been found in sharks, dogfish, and sea turtles by Hemmeter (*"Cardiovascular Diseases,"* New York, 1913). In them stimulation of the ganglia would, from a normal of 36, slow or even arrest the heart's action, according to the strength of the electric current. There is a "balanced mechanism" in the nerve supply of the heart, in which each of the antagonistic forces is peculiarly susceptible to a stimulus. But the heart beats in the fetus before any trace of nerve fibers can be found. Indeed, the muscle tissue of the heart may act independently of any nervous influence.

The paroxysmal cases may be due

to reflex excitations of the pneumogastric, though the stimulus of almost any afferent (sympathetic) nerve (such, for example, as the abdominal sympathetic) may cause them, for a blow on the abdomen conveys the impulse to the medulla through the pneumogastric, slowing or stopping cardiac action. These attacks may also be due to depression of the augmentors, such as occurs in nervous or muscular strain, and in gastrointestinal irritation. They may also be caused by diminished action of the accelerators.

The central nervous system is known to furnish the heart with two sorts of nerve fibers. One of these, known as the inhibitory, reaches the heart through the medium of the valves. Their activity will slow or even arrest the heart's action. Luciani (*"Physiologie des mensch.,"* Münch., vol. i, pp. 168-173) calls the vagus the diastolic nerve of the heart, its stimulation causing dilatation of both auricle and ventricle. The second sort of fibers reaches the heart through the medium of the sympathetic system. They are called accelerator fibers because they quicken the heart's action. The upper and lower branches of the vagus unite in the heart with the sympathetic network so as to form the cardiac plexus, filaments from the vagus, however, terminating in the sinoauricular node, *i.e.*, the remains of the sinus venosus.

Both vagus and sympathetic fibers are efferent in character, but there are also afferent filaments, carrying sensations away from the heart. Some of these are stimulated at each beat of the heart. These latter fibers may cause painful sensations, for the stimulated vagus may send radia-

tions to various sensory nerves. But the cardiac plexus lies on the arch and ascending portions of the aorta, and from it the heart receives both inhibitory and accelerator fibers.

Now, as the result of a very large number of experiments, it seems certain that the vagus affects both the rate and the force of cardiac contractions, and also the conductivity of contractions that normally pass from the auricle to the ventricle. The familiar experiment of pressure on the vagus in the neck causes, it will be remembered, slower and stronger cardiac contractions, while, on the other hand, if the auricle is injured in any way or pressed upon, permanent or temporary loss of conductivity, as the case may be, is liable to follow. Indeed, experiments have shown that injury to the auricle or pressure on it may so disturb the conductivity that, of several auricular contractions, few or perhaps only one ventricular contraction may follow; in other words, there will be heart block. Direct stimulation of the vagus in lower animals may even keep the heart inhibited for several hours; or the inhibition may be indirect, and due to a blow on the abdomen, or distention of the stomach or intestines by gas, this latter accident causing the heart to stop entirely. I have seen a case of complete temporary heart-failure of this kind in which the respiration also was suspended, so that death seemed to have taken place.

An explanation of this phenomenon given by Howell ("Textbook of Physiology," Phila., 1911) is that the afferent impulse conveyed to the central nervous system stimulates those nerve cells in the medulla that give origin to the inhibitory fibers causing

cessation of cardiac action, while also an afferent impulse may excite the activity of the accelerator nerves, by reacting on their roots, presumably somewhere in the brain. The group of cells from which the vagus arises comprises the so-called cardioinhibitory center, but its anatomical site is as yet unknown. These cells in health should presumably be in constant tonic activity, and it is through their influence that the rate of the pulse is kept down by their opposition to the activity of the accelerators, for the rate of a pulse is due to the resultant of the antagonistic forces of these two opposing agencies. In my case mentioned above an afferent impulse conveyed to the nuclei of the vagus seems to have paralyzed temporarily the inhibitory fibers.

There may or may not be subjective symptoms. In the physiologically infrequent pulse, such as the hereditary, or congenital, or pulse of pregnancy, there are no untoward symptoms. In fact, evidence goes to show that in most of them, or certainly in many, an increase in rate begets disagreeable sensations.

On the other hand, the infrequent pulses of the infections, such as typhoid and the toxemias; poisoning by tobacco, digitalis, tea, or coffee; uremia and anemia, diphtheria, cholesteremia, and syphilis, are so wrapped up in the symptomatology of their several affections that a description of their several symptoms would carry us beyond the scope of this article.

We have now to consider the remaining forms of the neurotic variation of the infrequent pulse, the so-called idiopathic form.

Vertigo, convulsions, or unconsciousness, of short or long duration; epileptiform or apoplectiform seizures, loss of rhythm, Cheyne-Stokes respiration, and a synchronous pulsation of auricles and ventricles, which come on without warning or with an ill-defined aura, have now been erected into a group under the name of the Stokes-Adams syndrome, because these two men were the first to describe it.

Cases of Stokes-Adams syndrome may survive for several years. From our present knowledge we infer that the attacks may be induced by an anemia of the nervous system, brought about by the slow action or temporary arrest of ventricular systole. It may also be due to some affection of the cardiac muscle which lessens its susceptibility to nerve influence.

Two of my cases of Adams-Stokes disease lived over two years from the beginning of the attacks. One is now living and in fair health, having survived the attacks for upward of twelve years.

Heart block is a condition in which the ventricle fails to respond to the auricular impulse. It is partial when the ventricle responds occasionally, complete when it does not respond at all. It may be produced either by a defect in the conducting substance of the His bundle or brain, or the failure to respond may be due to nerve implication or to muscular inability of the heart.

At present we recognize four forms of this disturbed conductivity:—

1. *Acute* heart block, due usually to the misuse of drugs.

2. *Partial* heart block, where the stimulus is occasionally carried through, as shown by an alternation

between the normal rate and the slow rate.

3. *Complete* heart block, where the auricle and ventricle contract independently.

4. The *Adams-Stokes syndrome*, where loss of conductivity is associated with syncopal attacks.

It is easy to make the diagnosis of the infrequent pulse, but it may be difficult or even impossible to determine under which variety it is to be placed. Indeed, whenever possible instruments of precision, like the sphygmograph, cardiograph, or polygraph, should be used to ascertain the precise relations of the cardiac action to the arterial and venous pulses.

Next, it should be determined whether the pulse is physiological or pathological, and whether it is paroxysmal or permanent. Each has a different expectation. In the majority of cases, according to Grob in 80 per cent., the pulse is associated with or is a sequel to some one of a very large number of conditions, among which, as we have seen, are poisoning by lead, tobacco, or tea; the several infections, such as syphilis or diphtheria; reflex conditions from skin diseases or gastrointestinal irritation, and the prognosis will depend largely on the degree of success in treating the underlying disease. The physiologically infrequent pulse is very rare, and it does not seem to affect the expectation of life, as far as we know. In Stokes-Adams disease the prognosis is doubtful. Patients may live for years, however, without any alteration in the physical signs of circulatory disease. In heart block the prognosis is grave. Occasionally a patient may live a com-

paratively comfortable life for a very few years, provided he is free from mental and physical strains, has the necessary creature comforts, and can lead a quiet and uneventful life.

The physiological cases require no special treatment. Those that are associated with, or are consequent to, the very large number of affections that have been mentioned, a list that is constantly increasing as we study these cases more thoroughly, should be treated chiefly with a view to the underlying disease. In heart block, if we are inclined to believe that the infrequent pulse is due to excessive vagus influence, we should give **sulphate or nitrate of atropine**, in $\frac{1}{60}$ -grain (0.001 Gm.) doses, to aid the diagnosis. Atropine relieves functional heart block by paralyzing the vagus terminals, raising the arterial rate up to the venous. It is usually though not always effective, but has no curative value. In the Stokes-Adams syndrome, when the vertigo, epileptiform convulsions, or unconsciousness are assumed to be due to arrest of ventricular contractions, causing cerebrospinal anemia, Dock has reported a case where **nitrate of strychnine** was given in $\frac{1}{20}$ -grain (0.003 Gm.) doses with successful results. Probably a good preparation of **cactus**, whose action is similar to that of strychnine, may be used with advantage. If there is high pressure, **nitroglycerin** in doses of $\frac{1}{200}$ to $\frac{1}{100}$ grain (0.0003 to 0.0006 Gm.) has proved useful. **Digitalis** is absolutely contraindicated in permanent heart block, but in Stokes-Adams disease it may, according to my experience, be used with advantage. **Morphine** should be used cautiously. If the heart block is acute and caused

by digitalis, the use of the drug should, of course, be suspended at once. If syphilis exists, antisyphilitic remedies should be used according to our established rules, and in sufficient quantities. If any form of **salvarsan** is used, **mercury** should be given as well, with or without **iodides**. In the treatment no greater mistake can be committed than in aiming to accelerate the pulse by medication only. Experience has abundantly shown that such treatment has bad results. In the paroxysmal forms of the infrequent pulse the prognosis depends on our success in mastering the disease of which it is a symptom, but when it is due to a functional nervous disturbance, or we are in doubt as to its exact cause, sedatives like the **monobromate of camphor**, **asafetida**, **valerian**, and **Hoffmann's ether** are the remedies *par excellence*, together with **carbonated baths** and **resistance exercises**, carefully regulated **diet**, and observance of the sound rules of health.

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HEART, PALPITATION OF THE.—Although the term "palpitation" means the rhythmical normal action of the heart, it is commonly applied to undue frequency of the beats, sufficiently marked to cause discomfort, accompanied by more or less irregularity in the rhythm and, in marked cases, precordial distress, dyspnea, and anxiety.

SYMPTOMS.—The slight attacks of palpitation with which most of us are familiar are accompanied by more or less oppression and precordial distress. During violent paroxysms these manifestations are increased in proportion, and the heart beats may become tumultuous; the beat against the chest is violent; the patient can only speak with the greatest difficulty; his face is pale and covered

with cold sweat, and he may suddenly lapse into unconsciousness. While the arteries throb violently, the throbbing may not correspond with the cardiac pulsations. The radial pulse may seem quite normal and violent cardiac action exist. Again, the heart may simply beat with greatly increased force without necessarily involving the rapidity of its pulsations.

Frequently repeated palpitations caused by emotions, excitement, and excessive exertion may predispose the heart to the disorder, with paroxysms of dyspnea and precordial pain in some cases. This form, termed by Da Costa *irritable heart*, was common among soldiers during the Civil War and the recent war, and is viewed under the next heading.

In some cases—individuals subject to “stage fright,” for instance—violent palpitations may precede entrance upon the stage; as soon as this is accomplished, the heart's action becomes regular in every way. Mental exertion here does what physical exertion will do in other cases, and what is foolishly branded “coward-ice” in some young soldiers is often but the cardiac manifestation of excitement, which soon disappears after an action involving physical effort has begun. In some cases, especially hysterical women, the least emotion may bring on an attack.

DIAGNOSIS.—The physical signs are negative in mild cases, as a rule, unless some form of valvular disease be present. The ring of the sounds is merely accentuated. In cases of anemia or neurasthenia a murmur is sometimes heard.

In severe cases the cardiac impulse is forcible and venous throbbing is noticeable. The pulse is full, hard, and rapid, attaining 170 or more in some subjects. In anemic individuals, who are prone to palpitation, anemic murmurs may be heard on auscultation besides the exaggerated cardiac sounds.

Valvular disorders often give rise to palpitations, but the true identity of the causative trouble may readily be established by auscultation.

ETIOLOGY.—Palpitation is much more frequently met with among females than males, especially around puberty and the menopause. Uterine and ovarian affections and hysteria are commonly ob-

served in cases subject to cardiac neuroses of all kinds. It is often a complication of menopause.

In men it is liable to occur when the anxiety of business and responsibilities of life accumulate. Emotions, excitement, and fear are well-known causes. The abuse of certain beverages, particularly tea and coffee, is often a factor in the history of some cases. The inordinate use of tobacco may be included in this class. Various diseases—especially digestive disturbances, anemia, and chronic valvular disorders—are active as causative disorders in but a small proportion of cases. It may follow acute fevers and continued overexertion, witnessed in armies—the “irritable heart” referred to above. Acute infectious diseases may cause palpitation owing to the morbid effects of toxins upon the nervous mechanism of the heart.

TREATMENT.—To arrest a paroxysm of palpitation **rest** in the recumbent position in a well-ventilated, darkened room and loosening of the clothing should precede all other measures. Sipping **cold water** or eating **cracked ice** and the application of a **cold compress over the heart** often suffice to arrest the paroxysm. Digital **pressure upon the vagus** below the angle of the jaw or **over the ovaries** are helpful. A **spray** of a 5 per cent. **solution of cocaine** may be used in the **nostrils** and may prove effective reflexly. A warm, **stimulating drink**, **aromatic spirit of ammonia**, and in hysterical subjects the **bromides** and **valerian** are often effective. **Camphor monobromate**, **oxygen inhalations**, and, as a last resort, **morphine hypodermically**, have been highly recommended. Sometimes palpitations are due to an overloaded stomach, or to the presence of indigested food in this viscus; an **emetic** is then indicated and proves rapidly effective.

In paroxysmal tachycardia the following measures are recommended by Vaquez to overcome the paroxysm:—

1. **Lying on his back**, the patient should execute **very slow inspiratory movement**, keeping the chest well filled with air during the intervals.
2. He should drink **water** or some other fluid, executing **energetic swal-**

lowing movements. 3. Every ten minutes he should take a cachet containing 0.15 Gm. ($2\frac{1}{2}$ grains) of **pituitary gland** substance. 4. Mild compression of the right pneumogastric nerve in the neck. 5. **Tickling of the pharynx with a feather.** 6. If the condition is not relieved in twenty-four hours, the patient should be given 2 dessertspoonfuls of syrup of **ipeacac** at a ten-minute interval. 7. If the tachycardia should happen to persist longer than three or four days, and signs of marked cardiac insufficiency appear, an intramuscular injection of 0.5 mg. ($\frac{1}{2}$ grain) of amorphous **strophanthin** should be given; on the next day, 1 mg. ($\frac{1}{4}$ grain) by the same route, and on the third day, if necessary, an intravenous injection of 1 mg. C. Esmein (Jour. méd. français, Feb., 1913).

To prevent recurrence of the attacks the cause should be sought and eliminated. In many cases it is due to excessive coffee or tea drinking or to inordinate smoking, and in some to masturbation or excessive venery. S.

HEART, IRRITABLE.

This condition, first described by Prof. J. M. DaCosta, of Philadelphia, who had studied it during the Civil War, was particularly prevalent during the late European conflict. It represented, according to Meakins, Thomas Lewis and others (Brit. Med. Jour., Sept. 23, 1916), from 50 to 55 per cent. of all cardiac diseases encountered by them among soldiers.

Symptoms.—Pallor, paroxysmal dyspnea, fatigue, and even exhaustion, on moderate exertion, sometimes accompanied by pain about the heart, tachycardia, the pulse-rate reaching often 120, and occasionally attended with arrhythmia, both increased by exertion, more or less insomnia, are the more prominent symptoms; slight cyanosis, especially of the lips, is

occasionally observed, also vertigo and fainting. Lian (Presse méd., May 22, 1916) states that in light cases it appears only on marching, and passes off with rest, but that in others it persists even in recumbency, with a pulse-rate often of 100.

The physical signs are variable. Systolic murmurs are frequent; the heart is usually dilated to an appreciable extent. Most authors hold that the blood-pressures, both systolic and diastolic, are low, but according to Martinet (Presse méd., Nov. 4, 1915), this is only exceptionally the case, both being high as a rule.

Irritable Heart in Recruits.—A. Morrison (Brit. Med. Jour., Oct. 30, 1915), on the basis of considerable experience in determining the suitability of officers and men for military service on account of some cardiac condition or anomaly, comments on Sir James Mackenzie's conclusion that an *organic valvular lesion* should not be regarded as a reason for rejection, provided the muscular action of the heart be satisfactory. The British Army Medical Service, however, had found it advisable to absolutely reject a recruit with organic valvular disease. This applies also to *endocardial murmurs*, an *extrasystolic heart*, and *auricular fibrillation*, usually found associated with mitral valvular disease. A man may be accepted, however, when functional bruit at the apex disappears on assuming the erect position; when he shows a rhythmical variation of pulsation associated with respiration, associated perhaps with an occasional reduplication of the second sound, the symptoms being purely physiological.

In determining the incidence in 10,000 cases in recruits of various diseases which have been supposed to lead to damage of the cardiac valves or myocardium, a history of rheumatic fever was obtained in 19.2 per cent.; chorea, 2.6 per cent.; rheumatism, 16.1 per cent.; growing pains, 26.5 per cent.; tonsillitis, 22.1 per cent.; scarlet fever, 21.8 per cent.; diphtheria,

7.2 per cent.; pneumonia, 5.3 per cent.; influenza, 56.0 per cent.; syphilis, 2.0 per cent.; gonorrhea, 5.95 per cent., and strain, 27.1 per cent. Wells (Brit. Med. Jour., Sept. 7, 1918).

J. K. Fowler (Brit. Med. Jour., Nov. 20, 1915) lays stress on the effect of change of position upon the sound. Unless a case of suspected valve disease is examined both in the standing and recumbent position, he deems it of no value. A functional and false murmur which often disappears when the patient lies down, is almost certainly not due to valvular disease. Parkinson (Lancet, July 22, 1916) found that some simple exertion test, such as climbing 25 to 50 steps, reproduces the symptoms, and so furnishes valuable information on the functional efficiency of the heart, if such be present.

The physical signs suffice, according to Meakins and Lewis (Brit. Med. Jour., Sept. 23, 1916), to recognize about 40 per cent. of the men referred to them for cardiac symptoms as unfit. Most of the others showed various symptoms, dyspnea, palpitation, vertigo, or fainting. By suitable exercises an additional 5 per cent. of the original group were found unfit for service, but in all about 50 to 55 per cent. of soldiers suffering from cardiac symptoms were found fit for some form of military duty by the tests. All of the men in this group were suffering from what has recently been called "irritable heart."

The writer emphasizes the satisfactory showing made in active service by 12 men suffering from chronic valvular or myocardial disease, when prophylaxis through the use of the intermittent small doses of digitalis, to prevent sudden dilatation under active exertion, is insured. In most instances, 0.1 mg. ($\frac{1}{650}$ grain) of crystalline **digitalin** (French) was given on 2 or 3 consecutive days in each week. Where signs of myocardial weakening under stress had already been discerned, the drug was given during periods of 10 consecutive days, separated by 4-day intervals. Primarily valvular affections withstood active service better than the myocardial cases. C. Fiessinger (Bull. de l'Acad. de Med., Dec. 29, 1914).

The patients tend to brood over their trouble. Binet (Presse méd., Aug. 10, 1916) found that emotional influences, shell or bomb fire, and the fatigue due to long marches, etc., could also cause a persistent bradycardia, the pulse being slowed from 70 to 50, while in others it showed acceleration—120 or more. The latter appeared mainly among the more timid men.

Etiology.—The precise etiology of irritable heart is still obscure, according to Abrahamson (Lancet, Mar. 24, 1917). Believing that the heart cannot be damaged by overstrain, even that incident upon warfare, he incriminates toxins, the ductless glands, and the vascular nervous mechanism rather than the heart itself. Kramer (Nederl. Tijdschr. f. Geneesk., June 24, 1916) blames the excessive use of tobacco, the palpitations and arrhythmia having ceased on stopping its use. Cola tablets are stated to cause the insomnia, and the abnormal use of coffee, tea and concentrated foods, for the hyperthyroidism, accompanied in some instances by perceptible enlargement of the thyroid.

Sajous (Pa. State Med. Jour., Jan., 1919) adds that true soldiers' irritable heart is mainly due to excessive activity of the adrenals, induced by fear, excitement, etc., leading to exhaustion of these organs. The heart and blood-vessels being deprived of the organic substances which sustain their tone, the specific symptoms of the disorder are awakened. In cases predisposed to thyroid disorders, the same would hold however that it may be the result of hyperthyroidism, local or progressive.

Adrenalin acting as a stimulant to the sympathetic nervous system, Goetsch's test, used by him especially in the study of thyroid disease, was employed to detect the cases susceptible to irritable heart. Of 65 patients, the adrenalin test was positive

in 39 (60 per cent.), doubtful or suggestive in 6 (10 per cent.), and negative in 19 (30 per cent.). In considering these results one must accept the fact that the clinical group dealt with does not necessarily represent one single clinical entity. Peabody, Clough, Sturgis, Wearn and Tompkins (Jour. Amer. Med. Assoc., Dec. 7, 1918).

Pathology.—Various authors, Monckeberg, Rehfish (Berl. klin. Woch. Nov. 29, 1915) and others, found that as a result of military hardships, arteriosclerosis developed in a large proportion of cases, 43 per cent. as shown by autopsies,—a possible factor of cardiac irritability. The complete recovery of most of these cases tends to refute this view. Aschenheim (Münch. med. Woch., May 18, 1915) found the testicles of 74 per cent. of cardiac neuroses smaller than normal, with scanty hair, etc., and suggests a predisposing constitutional inferiority, which affects also the ductless glands.

Treatment.—On the whole, **rest** and **digitalis**, and very gradual resumption of physical exercise are indicated. The following mixture was found extremely beneficial by I. Mackenzie (Glasgow Med. Jour., Oct., 1916) in many cases of "soldiers' heart":—

R. Ammon. brom. 24 Gm. (6 dr.).
Liq. extract ergot .. 24 c.c. (6 dr.).
Tinct. digitalis 8 c.c. (2 dr.).
Spt. ammon. aromat. 16 c.c. (½ oz.).
Aque ad 180 c.c. (11 oz.).

M. Sig: (1) One-half ounce in water, after meals every 4 hours for 2 days; (2) one-half ounce in water, after meals 3 times a day for a week after; (3) gradually reduce to twice daily, and then once daily according to reaction.

After the abnormal fatigue ceases,

massage is indicated, and also **cool baths** instead of warm baths. Graded exercise should then be started under observation.

HEART, UNCOMMON DISORDERS OF THE.

TUMORS OF THE HEART.

Growths of the heart are infrequently observed. They include lipoma, myoma, angioma, cyst, gumma, sarcoma, and carcinoma, the last two being usually secondary.

SYMPTOMS.—Up to very recently these cases were seldom recognized during life.

The symptomatology of cardiac tumor varies, of course, with location of the growth. When involving the left auricle, a not infrequent site, the symptoms are, as a rule, rather clearly defined. The dyspnea is out of proportion with the apparent degree of cardiac involvement and shows paroxysmal exacerbations due to momentary blocking of one of the orifices. Brief syncopal attacks, with or without loss of consciousness, are to be similarly explained. Rapid loss of weight and strength is of diagnostic value. The area of cardiac dullness may be considerably enlarged, and a systolic murmur or reduplication of the second sound be noted, according to the situation of the growth. Irregularity of rhythm also appears to be frequent, and is but temporarily, or not at all, overcome by heart tonics. Especially distinctive, however, is the marked variability and disconcerting vagueness of the signs present. Multiple embolism, lung infarction, and sudden, unexpected exitus are also characteristic. An esophageal pulse tracing, when compared with the jugular tracing, shows that the

auricles are not contracting equally. Bard has found that the esophageal tracing shows a much less pronounced postsystolic rise than normal, the curve at this point attaining a level much lower than that of the presystolic and systolic elevations, whereas normally the opposite is the case. This is due to rigidity of the posterior wall of the left auricle owing to its infiltration by the tumor. Another abnormality is the marked diminution in the presystolic rise, which contrasts with the normal rise seen in the jugular tracing and referable, therefore, to the right auricle.

The history of the case may afford considerable aid. Thus, as shown by Huchard and Fiessinger, the occurrence in old syphilitics of a gradually progressive dyspnea, edema, and cyanosis, with often a small, rapid, high tension, and perhaps arrhythmic pulse, is very suggestive of cardiac gumma, which appropriate measures soon overcome, where cardiac therapy on the usual lines will prove absolutely sterile in results.

TREATMENT.—It is safe in all such cases to try mercurials, preferably the **biniodide of mercury**, in $\frac{1}{16}$ -grain (0.004 Gm.) doses thrice daily or **sodium iodide** in increasing doses, especially when the usual measures addressed to cardiac disorders fail to procure benefit. If cachexia suggests the possible presence of sarcoma, **Coley's fluid** might be tried. Several cases are on record in which cardiac conditions developing in luetic patients have been either cured or greatly improved by specific treatment associated with very little cardiac therapy.

PARASITES OF THE HEART.

The parasites which may occur, though rarely, in the heart muscle

are: echinococci and cysticeri, *Trichina spiralis*, and *Streptothrix actinomyces*.

SYMPTOMS.—Although the morbid process caused by echinococci, the parasite most commonly found in the cardiac muscle, may be advanced, the patient may show no impairment of health until he suddenly falls into coma, soon followed by death.

Again, the lethal course may be gradual, the patient, though previously well, experiencing severe pain in the epigastric region, dyspnea, cyanosis, feeble and irregular pulse, and finally syncope.

The known presence of echinococci in other parts of the body should suggest possible involvement of the heart when cardiac phenomena appear. What diagnostic signs we have are limited to those observed in tumor of the heart, a subject considered under the preceding heading.

TREATMENT.—Obviously the surgical measures adopted in echinococcus disease elsewhere can hardly be carried out in the heart, even though a correct diagnosis be made, which is very rare. The presence of parasites elsewhere in the body being accompanied by cardiac phenomena, what internal treatment may prove of service for the parasite which happens to be present in a given case should be employed. These various agents are enumerated in the article on PARASITES.

ANEURISM OF THE HEART.

A cardiac aneurism may involve the myocardium, the valves, or the coronaries without apparent preference for either of these arteries and very near its origin from the aorta.

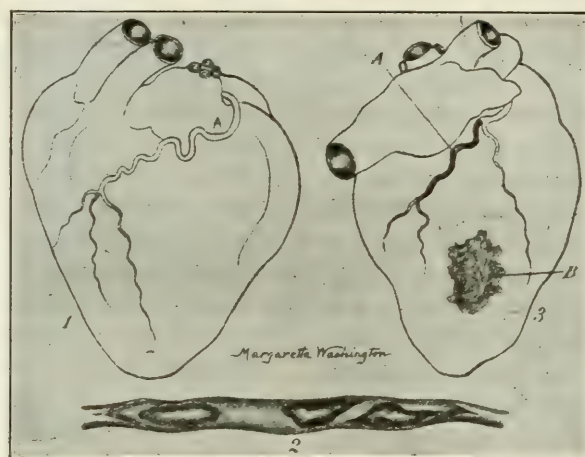
Case of aneurism of the cardiac wall with autopsy. The most prob-

able frequent cause is myocardial fibrosis resulting from interference with the circulation in the coronary arteries, which were sclerotic and had their orifices contracted in the author's patient. This explains the most frequent seat of the aneurism, which is in the apical third of the left ventricle and most frequently on the anterior surface. J. B. McElroy (Jour. Amer. Med. Assoc., Aug. 1, 1908).

SYMPTOMS.—According to Kasem-Beck, as previously shown by

cerned. An X-ray examination is very helpful as an aid to diagnosis. Valvular aneurisms which sometimes occur in the course of ulcerative endocarditis cannot be recognized during life.

Case in which there was a cavity with a fibrous rim, just under the chordæ tendineæ, about 8 c.c. from the apex. This cavity contained a large clot. The valves were all normal, except the mitral, which contained a few thickenings. The pathological



Aneurism of the heart with thrombosis of the left coronary artery. (Daland.) 1. Extreme tortuosity of the right coronary artery. 2. The right coronary artery laid open so as to make visible the masses of fibroid material in the wall, which projected into the lumen of the vessel to such an extent as to cause almost complete occlusion. When the artery was emptied of blood a very fine probe could be passed through it by lifting the thinner portion of the wall away from these masses. 3. (A) A moderately tortuous left coronary artery, the shaded portion of which represents the regions filled by a thrombus; B shows the location of an area of chronic pericarditis, immediately overlying the aneurism of the heart.

Skoda, a marked heaving of the intercostal spaces with the heart beat in conjunction with a small pulse curve in the radial artery is a certain sign of aneurism of the left ventricle. Coronary aneurism does not seem to give rise to any characteristic symptom, though dyspnea, cough, and fleeting pains about the heart may be complained of. Dullness on percussion, a pulsating prominence, and perhaps a blowing murmur may be dis-

diagnosis in the case was hydrothorax, pericarditis, mitral insufficiency, hypertrophy of left ventricle, dilatation of right ventricle, aneurism of the left ventricle in the upper third near the auricle. Voorsanger (Calif. State Jour. of Med., July, 1907).

Case of aneurism due to gradual occlusion of the coronary artery by atheromatous changes. There was extreme generalized arteriosclerosis, not caused by syphilis. The diagnosis was made *post mortem*. Betts (Med. Rec., Feb. 25, 1911).

The course of these cases is toward death, which may result from gradual exhaustion of the heart or rupture. Coronary aneurisms usually terminate by rupture into the pericardium and death. Valvular aneurisms likewise tend to rupture, leaving the affected valve incompetent.

TREATMENT.—So far therapeutic resources have proved unavailing, though some benefit has resulted from the use of **gelatin**. Whatever methods for the treatment of aneurisms in other parts can here be utilized should, however, be tried. (See **ANEURISM, TREATMENT OF**, Vol. I.)

MOVABLE, MOBILE, OR WANDERING HEART.

Although too much importance should not be ascribed to variations of position of the heart as compared with the average limits of mobility, there are cases in which this is excessive and in which appropriate measures will afford relief. In a case reported by Rumpf, for instance, the apex beat shifted 13 cm. when the position of the body was changed sidewise, while the average normal movement of a normal heart is $3\frac{1}{2}$ cm.

SYMPTOMS.—In some cases there are no symptoms, but in the large majority there are attacks of palpitation, a sense of weakness with a tendency to vertigo, especially upon running or exertion, and also inability to lie upon the side, particularly the left, relief occurring promptly when the patient lies on his back or assumes the upright or semi-recumbent position. Some cases show incapacity for work, marked uneasiness and anxiety, asthma, and tachycardia

Downward displacement of the heart is due to weakening and relaxation of its supports without changes in its size or in the pressure in chest and abdomen. In a personal case the only symptoms were irregularity of the pulse and bradycardia. The patient was a girl of 7 who had entered the hospital on account of acute bronchitis. Basile (*Riforma Medica*, March 22, 1909).

Typical case of downward dislocation of the heart. The patient was a man of 22 with pronounced neurasthenia and symptoms on the part of the heart after exercise, pulsation in the epigastrium, and discomfort when the food passed from the esophagus into the stomach. This discomfort could be avoided by bending forward as he swallowed the food; this evidently removed the pressure of the sagging heart from the lower part of the esophagus. There were also signs of gastrointestinal atony. The apex beat was in the sixth interspace and very weak. Fiorito (*Riforma Medica*, May 1, 1911).

A diagnosis of movable heart is justified, according to Leusser, if the area of cardiac dullness, which is normal when the patient stands up or lies on the back, is replaced by an area of resonance between the sternum and the left border of the heart when the patient lies on the left side and when, at the same time, there is displacement of the systolic shock to the left and its return to its original position when the patient rolls on the back.

These cases must, of course, be differentiated from teratological abnormalities, such as dextrocardia, etc.

Dextrocardia, a local transposition, is comparatively rare and should not be confounded with the not uncommon cardiac displacement due to disease. Blodgett states that in the examination of 20,000 recruits for the German army only 2 cases of dextrocar-

dia were encountered. Aristotle was the first to describe transposed organs. It is of further historical interest that the wife of Henry IV of France (mother of Louis XIII) had the heart to the right of the sternum. Doolittle (Boston Med. and Surg. Jour., Nov. 14, 1907).

Two cases of familial dextrocardia observed in a brother and sister. No such condition existed in the parents, as far as is known, or in the one living brother. In the girl, who died from tuberculosis some years ago, the hospital report reads, "Heart situated on the right side, liver on the left." In the male the same conditions existed, the apex of the heart being located in the fifth intercostal space on the right side. The liver was situated on the left, the spleen on the right. The man was a hard worker and suffered from no circulatory disturbances. S. Neuhof (Jour. Amer. Med. Assoc., April 5, 1913).

ETIOLOGY.—An examination of 1000 persons with regard to mobility of the heart led Pick to conclude that in a very great majority of normal subjects there was no perceptible difference in the area of dullness on percussion, nor in the position of the apex, on change of position of the subject. In about 6 per cent. of the cases the heart settled somewhat toward the left when the subject lay on his left side, say $1\frac{1}{2}$ to 2 cm. (0.6 to 0.8 inch). Abnormal mobility was found in some healthy and powerful persons as an apparent congenital anomaly, and, again, as an accompaniment of organic disease of the heart and of other organs, without, however, any apparent etiological relation to the latter.

Abnormal mobility may develop as a result of emaciation, on account of the disappearance of pericardial and abdominal fat. Disorders which in-

crease the weight of the heart, such as hypertrophy, tumor, etc., may cause abnormal mobility, and also downward displacement, or cardioposis.

TREATMENT.—The causative disorder should be ascertained and remedied. In emaciated people **dietetic measures** calculated to increase tissue nutrition are, of course, indicated, with instruction of the patient as to the prophylactic means he should adopt to prevent the occurrence of symptoms, by **suitable positions in bed**, the **avoidance of fatigue**, etc. All of these tend to reassure him and to promote recovery. **Quinine**, **strychnine**, and **iron** and very small doses of **thyroid gland**, **baths**, **mental rest**, and **mild walking exercises**, **outdoor life** are often useful. In portly subjects and in sufferers from gastroposis and enteroposis an abdominal belt which by compressing the viscera tends to afford support to the diaphragm and overlying organs, sometimes suffices to arrest symptoms due to movable heart.

Case of displacement of the heart outside of the thorax. The child was born with the apex of the heart protruding through the left in the upper part of the sternum and through a gap in the skin. The writer pushed the heart back into the thorax and covered the defect with large autoflaps from the vicinity. The child developed into a healthy woman and has borne 3 children, 2 of whom were alive and healthy. Auscultation did not reveal anything abnormal in the heart action, although the apex beat was in the space left by the fissure in the sternum. The absence of a pericardium did not seem to have hampered the heart's function. M. Kirmisson (Bull. de l'Acad. de Méd., March 1, 1910).

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HEAT EXHAUSTION AND THERMIC FEVER.

HEAT EXHAUSTION.

By heat exhaustion is meant a condition of exhaustion brought on by great heat while the body is subjected to exertion, and is characterized by vasomotor paralysis, prostration, and a low temperature.

SYMPTOMS.—The symptoms vary in nature and intensity. There is a feeling of marked weakness after exertion; yawning and sighing are all that may be experienced in mild cases: if this condition becomes aggravated, the weakness lapses into intense prostration, with nausea, an unquenchable thirst, vertigo, pallor, and a cold perspiration. The patient sits or lies down in a cool place at this time, or he faints. Sometimes the loss of consciousness is only partial or evanescent, and the patient, especially if given a stimulant (aromatic spirit of ammonia, amyl nitrite, wine, etc.), may drop off into a quiet sleep, from which he awakens greatly improved.

In severe cases the patient suffers collapse, the pulse being then extremely weak and rapid, the perspiration very copious, and the temperature subnormal (95° to 96° F.—34.9° to 35.6° C.). Marked restlessness and muttering delirium are often observed. Cardiac failure may occur in weak or elderly individuals, but, as a rule, the patient recovers in a few hours under appropriate treatment, if the case is mild; while in the more severe, recovery may be delayed for a couple of days.

The literature shows that knowledge of this disease is in a chaotic state. All appear to be agreed that there exist various forms of insolation. All

writers differentiate clinically at least 2 forms, "sun or heatstroke" and "heat prostration"; a few authors describe as well a third form, "heat exhaustion." Sunstroke is characterized by the following: There is always a history of direct exposure to the sun, an abrupt onset, with complete loss of consciousness. The skin is as a rule hot, dry, and flushed. The body temperature is very high, the pulse full and of high tension. On the other hand, in heat prostration these symptoms are either lacking or their exact antithesis is present. Thus no history of direct exposure to the sun is found, but a history of being confined in a close, poorly ventilated room, and perhaps to exposure to artificial heat. The best examples of this form of insolation occur in stokers on steamers, and may occur even when the outside temperature is far below what is usually termed hot. The onset is gradual and consciousness is usually retained. The skin is not dry, hot, or flushed; on the contrary, it is cold, clammy, and pale. The temperature in these cases is variable, but never attains the height it attains in cases of sunstroke, rarely going over 102° F. The pulse is weak and thready. Assuming that the symptomatology discussed is correct, it should follow that cases of post-operative insolation are not cases of heatstroke but of heat prostration. Cases of post-operative insolation have been recorded in Boston, New York, and Philadelphia, and it is possible to account for the greater frequency of heatstrokes in these 3 cities by the fact that they are more compactly built up and many of the inhabitants live crowded together in tenements. Unnecessary superheating of the patient is conducive in a great measure to the occurrence of post-operative insolation. A. V. Moschowitz (Med. Rec., June 10, 1916).

The sequelæ most frequently observed in cases of heat exhaustion are: undue sensitiveness to even moderate temperatures; acceleration

of the pulse and respiration; disorders of digestion; headache and vertigo; tenderness of the spine; chromatopsia; irritability of disposition, particularly recurring with the onset of warm weather. Epilepsy and disorders of locomotion and sensation have also been observed. Impairment of memory and of the general aptitude is often witnessed.

The writer studied in 443 cases the psychical and nervous conditions following heatstroke. Among the psychical diseases coma and delirium were frequently observed. During the convalescing period characteristic disturbances of ill humor and depression, crying spells, feeling of oppression in the chest, tremor, tonic and clonic twitching of certain groups of muscles, swelling of muscles, unilateral perspiration of the body and other vasomotor disturbances occurred. Increased suggestibility, deficiency of will power, and now and then a stuporous behavior were observed. Hysteria is one of the most common nervous diseases following heatstroke. Steinhausen (Roth's *Jahresbericht*; Military Surgeon., Nov., 1908).

The writer witnessed a case in which the most striking condition about the patient was his extreme ataxia. He would lie perfectly still, but on attempting a sitting posture his head and shoulders would show symptoms of marked ataxia. In fact, even when lying in bed and protruding his tongue the movement was ataxic. Any movement of the arms and legs would bring about an extreme inco-ordination which was not influenced by closing the eyes. The patient could smile and was not at all emotional.

The patient's condition when he was removed from the hospital was only slightly improved from that when he was brought in, but his ataxia remained the same. T. H. Weisenburg (*Jour. Amer. Med. Assoc.*, June 29, 1912).

DIAGNOSIS.—Heat exhaustion, as distinguished from thermic fever, is marked by a subnormal temperature and feeble pulse. The syncope associated with cardiac failure or with concealed hemorrhage resembles heat exhaustion, being accompanied by a feeble pulse and subnormal temperature, which latter, however, is less marked in syncope. As the treatment of syncope and heat exhaustion is the same, the differentiation is not so vital as that between thermic fever and heat exhaustion. In the latter case diagnosis must be made, for the treatment of the two conditions is entirely opposite in character.

From acute alcoholism, heat exhaustion may be distinguished by the odor of alcohol and the previous history in the former condition.

As aids in differentiation we must always take into account the history of the affection, the mode of onset, the presence or absence of fever, the state of consciousness, the urine, skin, pulse, respiration, and the condition of the reflexes.

ETIOLOGY AND PATHOGENESIS.—Heat exhaustion is most often due to exposure of the head to the direct action of the sun. We meet, however, a large number of cases among stokers, laundry workers, steel workers and workers in rolling mills, and also persons who are crowded together, as sweatshop workers, or who live in hot, ill-ventilated, insanitary rooms, buildings, or barracks where direct sunlight is absent. Grouping these, we must allow that heat exhaustion may be due to any condition in which an excess of heat accumulates within the body, and in which the body does

not eliminate its noxious metabolic end-products, principally the acids. Abnormal heat is known to increase metabolism; and whenever the bodily heat production is in excess of the heat dissipation, symptoms of heat exhaustion are produced.

According to Hirsch, while heat is the primary factor, the immediate cause in the production of heat symptoms is a diminution of oxygen and retention of toxic elements. Vincent also holds to the toxic theory. Recent work, says Gordon, leads us to believe that there is some toxic element, having a paralyzing effect on the nervous system, which produces metabolic changes in the neurons, and that the effects of the sunstroke, according to the degree of autointoxication, will be manifested either in an ordinary attack of heat, exhaustion, or syncope, ending in unconsciousness or even death. If this be true, says Woolley, then heat exhaustion is an autointoxication engendered by substances formed within the body under normal conditions of heat retention. He surmises there is some chemical point common to sunstroke and shock, since heat accelerates chemical reaction and the symptoms of sunstroke and shock are similar, and the factor that seems the only probable one to him is the increased acid content of the tissues. This, in heat exhaustion, may be the result of increased catabolic chemical action, influenced by heat. In all cases we are led to believe that there is a decrease in the alkalinity of the blood, and, likewise, a diminution in the oxygen content of the body.

The influence of the violet and ultraviolet rays does not occupy so

important a position in the etiology of this condition as formerly, owing to the experiments of Freer, Gibbs, Bauer, Chamberlain, and Aron. Aron holds that the damage is done by the hyperthermia, produced by the heat rays (the red and ultrared) and not by the direct action of the sunlight.

The skin pigmentation of the negro allows utilization of the heat from without to such an extent that the organism does not need so many calories as the white man, while they stand exposure to heat very much better. Figueras (*Siglo Medico*, Mar. 26, 1921).

As to the effect of evaporation on heat dissipation, Hill has found that, so long as evaporation is active, high temperatures alone will not change the bodily temperature. The heat only produces serious results when evaporation is insufficient, as is shown by Aron's experiments with dogs, cats, guinea-pigs, and rabbits where evaporation takes place through the respiratory tract. Heat exhaustion is frequently observed in cities during the summer heat, especially in persons in whom the powers of resistance have been weakened by alcoholism, ill health, and overwork. It is also the variety of insolation usually observed in soldiers, and is especially marked in men unused to marching, or having malarial toxemia.

The writer, being on duty in the Philippine Islands, had an excellent opportunity to study the influence of temperature on newly arrived soldiers, and yet in spite of the excessive tropical heat there were very few cases of sunstroke. Among the natives this hardly ever occurred, whereas among the soldiers it happened in those who either foolishly exposed themselves or who drank. A soldier who had been drinking quite severely the native drink, *bino*,

distilled from some of the native plants, went through an hour's morning drill without difficulty. He ate very little breakfast and later on again drank, and while walking in the street in the full exposure of the sun suddenly fell down unconscious and remained so for some hours. He then woke up in an acute maniacal condition, ran to the barracks, seized his gun, and before he was caught ran to one of the shacks and attempted to kill a native.

These sudden attacks were not at all unusual, but in the writer's experience, no matter how much liquor a man drank, it was not until he was exposed to the heat that he would be at all affected and then very suddenly. T. H. Weisenburg (Jour. Amer. Med. Assoc., June 29, 1912).

PATHOLOGY.—Heat exhaustion is, according to H. C. Wood, a condition in which the heat center in the medulla is paralyzed by the excessive heat, with the result that heat is dissipated more rapidly than it is made.

PROPHYLAXIS.—The skin should be cleansed and kept clean, that evaporation may be free. The clothes should be loose and light, sufficiently thin to allow of a free circulation of air to facilitate evaporation. The diet should be light, and of easily digested food. Meats and rich food should be avoided, likewise all alcoholic drinks. For these last may be substituted plenty of cool (not iced) water or fruit juices. Avoid fatigue and worry, and direct exposure to the sun. The windows of rooms and dwelling houses should be open, but shaded so as to exclude the heat rays without interfering with the free circulation of air. Electric fans increase evaporation from the body, by keeping the air in motion. Cool baths are refreshing and beneficial.

When the heat is intense, all work should be reduced to a minimum, and a midday rest in a shady place be taken if possible. **Lemonade** encourages the action of the kidneys, and the **free use of water, internally**, will favor intestinal elimination and diminish intoxication from fecal stasis.

TREATMENT.—The patient should be put in a warm bed, with his head horizontal or but slightly raised, and covered with an ice-bag. Hot-water bottles, heated irons, or quart bottles or cans filled with hot water should be wrapped in flannel and applied around the patient's body to augment the bodily heat. Meanwhile, friction to the extremities will be beneficial. The patient is now covered with hot blankets, and is given hot stimulating drinks (hot milk, hot eggnog, bouillon, coffee, etc.). If the patient cannot swallow, or is unconscious, hypodermic stimulation will be indicated (strychnine, caffeine, digitalin, camphorated oil, or aromatic spirit of ammonia, in from 10- to 20- minim—0.6 to 1.25 c.c.—doses, well diluted with whisky).

THERMIC FEVER.

Thermic fever or heat apoplexy is an asphyxial form of heat prostration, characterized by sudden unconsciousness and high temperature. This variety of heat prostration is much less frequent than that previously described. True thermic fever is a common form of heat prostration, characterized by excessively high temperature, and differing from heat apoplexy only in that it is more intense.

SYMPTOMS.—In *heat apoplexy* dizziness, intense headache, the appearance of *muscæ volitantes*, marked

throbbing at the temples, dryness of the skin, and dyspnea are the usual premonitory signs. Suddenly the patient falls, convulsions occur, followed, occasionally, by all the symptoms of cerebral hemorrhage, except the hemiplegia, but ending with cardiac paralysis.

After the "heatstroke" the skin is dry and hot, and there are no signs of sweat. The surface temperature is 3.5° to 5.5° F. (1.9° to 3.1° C.) above the normal temperature of the skin. The deep temperature varies from 99.8° to 103° F. (37.6° to 39.4° C.). One of the cases was of so-called "heat exhaustion" with profuse sweating, collapse, and subnormal temperature, 95° F. (35° C.). Mitral incompetence was present, and possibly dates from the "heatstroke." The observations are too few and incomplete to justify conclusions or theories, but they show that the cases of so-called "heatstroke" are complex and obscure. With a high internal temperature and no sweating the temperature of the skin becomes abnormally high, and the body is warmed throughout. The heart appears to be affected, or it may be that men with weak hearts are more readily affected by the heat. M. S. Pembrey (*Brit. Med. Jour.*, Sept. 22, 1900).

In the majority of cases, however, this stage is not soon reached. Besides the first symptoms outlined, there is marked flushing of the face, which may become cyanotic; the breathing is stertorous; there are marked delirium, nausea, and vomiting, or, rather, retching, and the tongue is coated; epigastric cramps, oppression, rapid though full pulse, contraction of the pupils, hot and dry skin, petechiæ, labored or stertorous breathing, and a mousy odor of the body have also been noted. In these cases the temperature may be subnormal at

first, but it usually rises and may reach 105° or 106° F. (40.5° to 41.1° C.), exceptional cases very much higher (110° F.—43.3° C.).

As a rule, the attack was sudden and frequently soon after a full meal, when the production of CO₂ was increased. Cyanosis during the attack was not uncommon. At the height of an attack the urea in the urine was lessened. The Babinsky and Kernig phenomena were never observed. The coma of sunstroke resembles in many respects that of uremia, but, unlike the latter, is usually associated with hyperpyrexia. Jardini (*Clin. Modern.*, An. xii, N. 22-24, 1906).

In none of the articles calling general attention to muscular spasms in individuals whose occupations expose them to intense heat has any mention been made of this condition in professional cooks and chefs. Case in a negro 64 years of age who complained of some vague pains in the loins and back. He had noticed also that his urine was red and deposited a heavy sediment. He had been a professional cook for twelve years. He had never been ill except on some occasions when he got "overhet." Urged to amplify this somewhat, he said that very often while in an overheated kitchen he had been seized with cramps in the muscles, especially the muscles of the calf and of the abdomen. These were described as hard, tonic contractions and intensely painful; when they occurred he was compelled to go out into a cooler atmosphere and lie down for an hour or two, after which he could resume work. He had found 2 or 3 glasses of **lemonade** the best adjunct to treatment. The condition was familiar to him and to all cooks, at least on Pullman diners, where in the hot weather the temperature in the kitchen sometimes rose to 150° F. (65.6° C.). He knew one man who had been seized with generalized tonic spasms on duty, and who had died in the hospital at the end of his run. The spasms

tended to become worse and more frequent with time. Little was found on examination of this patient. His temperature was 98.3° F. (36.8° C.), his pulse 84. He had a coarse tremor in both hands, which was increased on voluntary movement. His reflexes were normal; there was no Babinski, no fibrillary twitchings in any muscles, nor were there any tonic spasms. His pupils reacted to light and distance. His urine was red, clear, and acid, with a specific gravity of 1.025, contained no albumin nor sugar, but on standing deposited a heavy sediment of urates.

While this condition is well known among Pullman chefs, it is not familiar to those who work in the better ventilated kitchens of hotels, restaurants, and cafés. Logan Clendening (Jour. Amer. Med. Assoc., May 7, 1910).

Thermic fever is attended by an excessively high temperature—sometimes 115°, 116° (46.1°, 46.7° C.), and even 117.8° F. (47.6° C.), as in the case observed by Lambert. This means death, preceded by intense dyspnea, asphyxia, and coma, in the majority of cases unless proper treatment is promptly instituted.

In a considerable proportion of cases there are preliminary symptoms which, if accepted as warning, may prevent development of the more dangerous features—nausea, cramps, progressively increasing weakness, vertigo, blurred vision, intense headache, and cessation of the perspiration. If these symptoms do not cause the patient to realize that he is in danger, and to repair to a cooler spot, the active symptoms of thermic fever appear. The skin, from dry, becomes flushed, red, and burning; it may finally assume a bluish tinge, while the mucous membranes become markedly cyanotic.

A thermometer left *in situ* would indicate that the temperature is steadily rising, and, though perhaps subnormal at first, reaching down as low as 95° F. (35° C.), it may reach the temperature already mentioned. The pulse follows the temperature, and is at first full, bounding, and non-compressible, then becomes rapid; the number of respirations also corresponds with the temperature, varying from 20 to 60 in the minute. The eyes are watery and fixed, and the pupil is contracted.

Clonic spasms, alternating with rigidity, are often observed. There is moaning, delirium, and jactitation, unconsciousness usually accompanying these symptoms. The urine and feces are passed involuntarily,—though the secretions are sometimes suppressed,—and exacerbations of dyspnea, noticeable from the start, gradually assume the state of asphyxia, followed by death. A fatal issue, however, does not always follow, and the use of appropriate means, especially the cold bath, often saves patients whose temperature has reached extraordinary limits.

The greatly depressed condition of the patients and the overvigorous measures employed to reduce the temperature have been the cause of pneumonia in these cases.

Among 160 cases of heat prostration at the Boston General Hospital, pneumonia occurred in 10.7 per cent. and was the cause of 20 per cent. of the 44 deaths. Though not more frequent after heatstroke than after heat prostration, in the former pneumonia was much more fatal. Of lobar pneumonia there were 7 cases with 2 deaths. Of bronchopneumonia there were 10 cases with 7 deaths. The greatest number of cases occurred between 20 and 30 years, but

the severest mortality was in the sixth decade of life. Alcohol and arteriosclerosis were fatal complications. Erysipelas and empyema necessitatis were sequelæ in 2 of the cases. Pneumonia as a complication of heat cases occurs in 10 per cent. of these cases and it causes 20 per cent. of the deaths. The pneumonia does not differ from that due to other causes. W. D. Reid (Boston Med. and Surg. Jour., Aug. 15, 1912).

ETIOLOGY.—Excessive heat in any form is usually considered as the main factor in the production of insolation. It may not only occur in the street, but also in a boiler-room, a laundry, etc., showing that heat is the predominant factor. Heat exhaustion may be brought about by excessive exertion under unfavorable conditions, while sunstroke is due to excessive heat and occurs during the hottest season of the year. The latter exhibits remarkable endemic characters, in that it is extremely prevalent in one locality, in another is totally absent, though the regions may be quite adjacent and under precisely similar climatic influences; again, its ravages in different years vary immensely and quite irrespective of heat.

The writer has made experiments on himself on the influence of high temperatures on the body which throw light on the causation of heatstroke. He confirmed Haldane's view that the essential factor in the production of heatstroke is the combination of excessive humidity and high temperature. It appears that in a moist atmosphere the heat-regulating mechanism of the body breaks down and the temperature begins to rise. The writer found that this occurred with a "wet bulb" temperature of 95° F. (35° C.). The rise of temperature increased progressively, being on the average 0.7° F. in the first hour, 1.2° F. in the second, and 1.5° F. in the third. All the experiments

pointed to the conclusion that, once the balance of the mechanism of heat-regulation was definitely upset by high external temperature and almost total abolition of heat loss in evaporation, a vicious circle is established. The bodily temperature rises and as a result the oxidation processes, and therefore the production of heat, also increase and the body temperature rises still further. Once this process has been set going, it slowly but surely increases in speed. Not only does the body temperature rise while the external temperature still remains constant, but the rise gradually becomes more rapid. With this rise there was a great increase in the consumption of carbohydrates, which are the first to be sacrificed when the heat-regulating mechanism breaks down. Harvey Sutton (Jour. Amer. Med. Assoc., Nov. 21, 1908).

Direct measurements of the absorption and permeability of various tissues of the body in regard to heat, with calculations of the total radiation of tropical sunshine, served to show that, even under favorable conditions of conduction and circulation, the total increase of temperature in the exposed skull is so considerable that an increased heating of the deeper layers, especially the cerebral cortex, through transmitted heat, appears to be possible. This secondary heating of the cerebral cortex, caused by transmission of the sun-rays absorbed by the cranial coverings, is presumably of greater significance in the origin of sunstroke than is the primary heating of the cerebral cortex through radiation. Schmidt (Archiv f. Hyg., Bd. lxxxv, 1908):

According to Phillips, meteorological conditions predispose to sunstroke, and these involve high temperature, relative humidity, wind, and climatological characteristics, as well as the direct rays of the sun. The attack is no more dependent on high temperature and direct insolation than it is on low relative humidity.

The reduction of physical resistance to the action of heat upon the nerve-centers and a secondary disturbance of metabolism are probably at the bottom of these cases. Thus, fatigue,—mental and physical,—insufficient food, insanitary surroundings, and worry are all noted as predisposing factors. Alcoholism is particularly active in this respect.

During 1905, which in Florence was marked by a sudden access of great heat, with high aqueous vapor tension and marked electric state of the atmosphere, the number of cases of sunstroke was considerably above the average. Most of the cases occurred in July, and had a mortality of 10 per cent. (9 per cent. men, 1 per cent. women), the greater male mortality being due to the fact that they worked more laboriously than the women and were more exposed to the heat. Jardini (*Clin. Modern.*, An. xii, N. 22-24, 1906).

Of 465 cases whose histories were known to Phillips out of a total of 841 cases, 30 per cent. were alcoholic, 50 per cent. moderate drinkers, and 20 per cent. teetotalers; while of 70 deaths, 60 per cent. occurred in alcoholic patients, 30 per cent. in moderate drinkers, and only 10 per cent. in teetotalers.

Males are more frequently affected than females, and children—though less frequently attacked—are not free from the disorder, especially when the head is exposed to sun-rays.

The majority of cases occur in the afternoon, though cases are not infrequently observed at night, especially in poorly ventilated quarters. In stove-holes, boiler-rooms, sugar-refineries, etc., where the heat is intense, heatstrokes may occur at any time.

PATHOLOGY.—After a study of 805 cases of insolation, Lambert and

Van Gieson found that heat alone is not sufficient to explain all the clinical and pathological observations. The prodromal symptoms of sunstroke are those of acute functional disturbance, while the later symptoms, much more serious, point to grave changes in the blood and in all the nerve-centers, especially those of the latter which control the thermic mechanism of the body.

Van Gieson examined the brain and cord in several of Lambert's fatal cases, and found universal exhibition of acute degeneration of the neurons of the whole neural axis. In the cerebral cortex and cerebellum the cells showed the same degenerated changes; the cells of the spinal cord were not so extensively involved. The toxic agency of the symptoms of insolation seems to be shown by the changes found in the ganglion cells. They were, in every way, similar to those produced by a number of other poisons, such as by alcohol, lead, etc., and by bacterial products.

The experiments by Vallin would tend to show that coagulation of the albuminoid bodies occurs. The toxemia would thus occur as a result of arrested metabolism. The blood is dark, though fluid, and the corpuscles are crenated. In the hyperpyrexial form leucocytosis and degeneration of the red corpuscles may also be noted. Extravasations in the peripheral tissues are often found, and the body undergoes rapid putrefaction.

The pathogenesis of the high temperature noticed in thermic fever is explained by H. C. Wood: "There is in the pons or higher portion of the nervous system a center whose

function it is to inhibit the production of animal heat, and in the medulla oblongata a center (probably the vasomotor center) which regulates the dissipation of bodily heat. Fever is due to a disturbance of these centers so that more heat is produced than normal and proportionately less thrown off. Let it be supposed that a man is placed in such an atmosphere that he is unable to get rid of the heat which he is forming. The temperature of the body will slowly rise, and he may suffer from a general thermic fever. If early or late in this condition the inhibitory heat center becomes exhausted by the effort which it is making to control the formation of heat, or becomes paralyzed by the direct action of the excessive temperature already reached, then suddenly all tissues will begin to form heat with the utmost rapidity, the bodily temperature rises with a bound, and the man drops over with one of the forms of *coup de soleil*."

According to de Santi, insolation is in all cases characterized, from a pathological point of view, by arrest of the heart, but dependent on different causes. These may be classified as arising from intoxication by the products of muscular effort; from asphyxia; from a malarial infection called into activity by fatigue or heat. In the first form, that of intoxication by the products of muscular exertion, the victims are chiefly among soldiers unaccustomed to the fatigue of a march. The attacks occur when the temperature is high and the air is calm and humid, so that the cutaneous evaporation is small. Sambon has emphasized the microbic origin of insolation.

In the British army in India heat-stroke is most fatal and most prevalent where the heat is greatest and most oppressive, and at the time of the year when these influences are at their maximum. W. J. Buchanan (Lancet, Sept. 15, 1900).

Senfleben has demonstrated that the effects of heat prostration are the result of concentration of the blood, entailing destruction of red corpuscles with consequent escape of hemoglobin into the blood. The excess of hemoglobin leads, he says, to sudden intense destruction of white corpuscles—accompanied by high temperature—and consequent accumulation of fibrin ferment in the blood. This leads to coagulation at points in the capillary system, especially in the lungs and brain.

Since this theory requires coagulation of the venous blood in the lesser circulation, then one should find clots in the pulmonary artery and its branches in a patient dead from heat-stroke. No such findings have as yet been reported. Senfleben's explanation that the fibrin ferment has been used up does not explain the absence of a coagulum. F. J. Conzelmann (Military Surgeon, Sept., 1908).

The cerebrospinal fluid in a case of sunstroke. The case under the author's observation concerned a previously healthy man 26 years of age who after insolation began to present the signs of cerebral irritation, with a well-marked condition of mental confusion, lasting for two weeks. The first lumbar puncture, on the sixth day, yielded a hemorrhagic fluid, which escaped in a continuous stream and contained numerous polynuclear cells. The following punctures yielded an amber-colored fluid without blood-clots after centrifugalization; there were lymphocytes instead of the polynuclear cells. On the nineteenth day of the disease, the puncture fluid again presented a normal appearance. A mild lymphocytosis persisted for about five weeks longer.

The assumption of a process of intoxication is not required, to account for the effects of insolation. Dufour (*Comptes-rendus de la Soc. de Biol.*, vol. xlv, No. 5, 1909).

Not much is known of the pathology, chiefly because of the rarity of post-mortem examinations. Probably caused an autointoxication which in some cases induces multiple hemorrhages. T. H. Weisenburg (*Jour. Amer. Med. Assoc.*, June 29, 1912).

PROGNOSIS.—The prognosis depends not only on the severity of the case, but also upon prompt and appropriate treatment. Although some cases are almost instantly fatal, yet patients having a temperature of 110° F. (43.3° C.) have recovered under the prompt cold water treatment.

PROPHYLAXIS.—In addition to the suggestions offered under heat exhaustion, we would add that when persons are exposed to high heat, as in engine-rooms, factories, and in the hay-field, they should wear a **minimum of clothing**. **Cloths wet with cold water** may be **worn inside the cap or hat**. An abundant supply of **cool water** should be furnished for **drinking purposes**, as perspiration is favored by freely drinking of water. No alcoholics, and very little meat. **Fruits and vegetables**, with good **bread and butter**, should be the main portion of the **dietary**.

As the writer believes that the actinic theory of sunstroke is the correct one, he urges that soldiers' helmets should be **lined with orange red**; that their khaki coats should have a detachable **strip of orange red underneath the material along the spine**, and that the men should wear **shirts dyed this color**. Duncan (*Jour. of Tropical Med. and Hyg.*, March 1, 1907).

The writer ascribes the form of heatstroke experienced most fre-

quently by soldiers and workers in the fields to an intoxication by fatigue products, acting in conjunction with the heat of the sun. In subjects who are not performing an excess of muscular work, heat alone is incapable of causing death. Prophylaxis on this basis consists in insuring sufficient lung ventilation, oxygen destroying the toxic material and thus preventing heat stroke. For this purpose, the **thorax and shoulders** should be rendered as **free as possible, light clothing** of ample size being worn, without collar or tie. No burdens at the level of the kidneys should be permitted. At regular rest intervals, **forced respirations** should be practised, with the head thrown back and mouth open. The subject should carry with him a mixture of **water and vinegar**, which he should on occasion use to **moisten the face and snuff up into the nose** in order to stimulate the respiratory reflexes. Amar (*Presse méd.*, May 21, 1917).

TREATMENT. — Hydrotherapy and skilled and careful nursing seem to be chief factors in the treatment of insolation; frequent recording of the temperature, enabling the baths to be given at the earliest and, therefore, most effectual time; the use of the **ice tub-bath**, with constant and **general friction** of the entire surface, thus reducing the temperature in the shortest possible time, and being stimulating rather than depressing; the use of the same bath for all severe secondary elevations of temperature, and for the minor elevations, **sponge-baths of ice-water**, or of water at from 70° to 80° F. (21.1° to 26.7° C.), depending upon the individual case, and the repetition of these baths whenever the temperature is high enough to make them seem advisable.

At St. Vincent's Hospital, New York, the following method has given good results: The ambulances are

well supplied with **ice**, which is kept about the patient's head from the moment he is picked up until he enters the hospital.

Upon admission the patient is immediately stripped. His temperature, per rectum, is taken as he is being placed upon a raised stretcher or table.

The body of the patient is covered with a sheet, upon which are placed small pieces of ice. Large quantities are laid closely about the head. Ice-water from dippers, at a distance of from five to ten feet, are dashed with force upon the patient. This is continued about thirty or forty minutes.

The most efficacious stimulant, and one which has served to arouse when everything else has failed, was the pouring, from an elevation, of a fine **stream of ice-water upon the forehead**. As this treatment is very radical, it is continued for only one or two minutes at a time. In severe cases it is repeated several times, unless consciousness returns.

While this is going on, each patient, with very few exceptions, is given hypodermically 40 minims (2.5 c.c.) of the tincture of **digitalis** at one dose. Exception is in the case of the plethoric patients with high arterial tension. Upon such patients **venesection** is practised, and later tincture of digitalis is given in smaller doses.

The temperature is carefully watched; and when after hyperpyrexia it reaches 104° F. (40° C.), the patient is laid in a bed, covered with **blankets**, and **hot bottles** are placed about him.

When the temperature is reduced to 99° or 100° F. (37.2° or 37.8° C.) by bath, as is usually practised,

clinical history shows that it nearly always becomes subnormal—even falling at times as low as 91° F. (32.7° C.)—and leaves the patient in collapse. When the temperature is only reduced to 104° F. (40° C.) it will, in most cases, continue downward of its own accord.

Strychnine is never given. It has proved upon trial to cause convulsions or make them more violent. Convulsions are treated by **chloroform**.

When the secondary rise of temperature occurs, a sheet, wrung from ice-water, is spread over the patient, and kept wet until the temperature becomes normal. In some of the cases, where the secondary rise is very rapid, the entire **ice-and-water treatment** is repeated several times, or until the temperature remains normal. An **ice-cap** is kept upon the head from the time the temperature becomes normal until the patient is dismissed. This has been found of the utmost value.

In cases of prolonged unconsciousness patients are **nourished and stimulated** by means of the **stomach-tube**.

In extreme cases **hypodermics of whisky** are used.

As death seems the result of respiratory paralysis, **artificial respiration** is kept up for long periods of time—often half an hour or more. Surprising results are sometimes obtained.

The after-treatment consists of **light diet, stimulants, fresh air, the ice-cap**, and sudorifics, such as **ammonia**,—preferably the **spirit of Mindererus**,—in large doses.

Quoting a study of the treatment of thermic fever by Alexander Lambert (Med. News, July 24, 1897), the

writer points out that the lowest mortality recorded in that series of cases, 520 in number, was obtained by O'Dwyer in 197 cases treated at St. Vincent's Hospital by **affusions of ice-water combined with frictions**, until the temperature was reduced to 102° F. (38.9° C.), while the traditional ice pack and ice-bath gave mortalities ranging from 33 to 41 per cent. The fundamental principle of **hydrotherapy** in thermic fever is stimulation of the neurovascular mechanism of the body, which can be effected properly by ice-water affusions and frictions in place of the unscientific ice-bath or ice pack, which acts merely as an antipyretic of high potential. Simon Baruch (Med. Rec., July 1, 1911).

At the Boston City Hospital in 1911, the treatment in the *prostration stage, or heat apoplexy*, as described by W. D. Reid (Boston Med. and Surg. Jour., Oct. 26, 1911), consisted in **ice-cap, ice pack, cold pack, or sponge-bath**, according to the temperature, and **rest in bed**, with moderate **stimulation**, if there were signs of weakness.

In the *heatstroke type, or thermic fever*, there are four indications: (1) Reduction of temperature; (2) maintenance of cardiac action; (3) control of convulsions; (4) treatment of complications.

1. **Tub-baths and ice packs** were the choice in combating the high temperature. If the heart action was poor, the ice pack was always used, as the patient need not be moved as much. Vigorous **friction** seemed essential to good results. Also not a few cases were observed where too long continuance caused too great a reduction of temperature and a condition of collapse was induced. **Ice-water enemata** were used in a few instances, but, as a rule, a proper

use of external measures seemed sufficient.

2. Maintenance of cardiac action often required stimulation of a heroic type, mostly hypodermically, as the patients were generally unconscious. Generous use of **atropine** was practised for pulmonary edema, and **strychnine, camphor**, and various forms of shock enemata were directed at the failing heart. It was the general opinion among the house staff that the use of camphor, 2 grains (0.13 Gm.) in sterile oil by syringe, was of distinct value.

3. Convulsions were so frequent in the heatstroke cases that it became the practice toward the end of the so-called epidemic to administer a hypodermic of **morphine** and sometimes **hyoscine**, with the plan of repeating the morphine in case convulsions, nevertheless, developed.

4. The treatment of complications as they occurred varied in no way from cases in which they were the primary disease. About 5 of these unconscious men required **catheterization** for retention of urine.

In the Carney Hospital of Boston, as given by L. C. Walker (Boston Med. and Surg. Jour., Oct. 26, 1911), **hydrotherapy** was practically the treatment used. Those cases with a temperature below 101° F. (38.3° C.) were unmolested with the exception of removing their clothing and substituting a sheet for covering. About one-half of these cases were given 1 dram (4 c.c.) of the **aromatic spirit of ammonia**, well diluted in water, by mouth, and these patients seemed to recover more promptly and to feel better than those patients who did not get this treatment. The patients with a temperature of from 101° to

103° F. (38.3° to 39.4° C.) were given a cool pack, that is, they were wrapped in a sheet soaked in water at the temperature it came from the hydrant. Those cases with a temperature of from 104° to 105.6° F. (40° to 40.8° C.) were placed in sheets and sponged with tap water for ten or fifteen minutes, and this was followed by sponging with ice-water for ten or fifteen minutes, and they remained in the wet sheets until the temperature of the patient had become nearly normal, when dry sheets were substituted after the patient had been rubbed dry. The method and length of treatment by **hydrotherapy** were determined by the elevation in the temperature.

Those patients having a temperature of 107° F. (41.6° C.) and over gave most concern. These patients, 10 in number, all had convulsions more or less marked in severity. These cases first were sponged with **tap-water**, followed by **ice-water** sponging, and then in a few minutes were rubbed with **ice**, and if the temperature had dropped 2° F. (1.1° C.) or more they were left in the **wet sheets** for about one-half an hour, after which time the same treatment was repeated until a nearly normal temperature was reached. In 2 cases the convulsions were also speedily relieved, but with the remaining 8 cases **chloroform** anesthesia was administered at the same time **hydrotherapy** was used. In 5 cases fifteen to twenty minutes of deep chloroform anesthesia relieved the convulsions, but a longer time was necessary in the highest temperatures, and the patient with the 110° F. (43.3° C.) temperature was under deep anesthesia for about two hours,

with short intervals of light anesthesia, in order to determine whether convulsions were relieved or not. **Morphine**, in $\frac{1}{4}$ -grain (0.016 Gm.) doses, subcutaneously, repeated in a few minutes, was tried in 3 cases, but it seemed to have no effect in inhibiting the convulsions. As these high temperatures were accompanied by an irregular and poor quality pulse, **strychnine**, in $\frac{1}{30}$ -grain (0.002 Gm.) doses, subcutaneously, was given and repeated in one-half hour in 2 cases with apparently good results. Large doses of **atropine**, subcutaneously, were given to 2 patients whose respirations were shallow and weak, but no benefit was noted. Only one patient had a chill following the hydrotherapy, and **blankets** and **hot-water bottles** soon relieved this condition.

In the milder form of thermic fever of infants, **sponging the body with hydrant-water** and the administration of more **water internally** are all that is required. In the severe forms a **bath** the temperature of which is not below 60° F. (15.6° C.) may be used; at the same time **friction** should be vigorously applied to keep the peripheral arterioles dilated. **Stimulants** may be given as required. In the hyperpyrexial forms it is well to make the skin intensely red, as by **nitroglycerin**, **friction** with towel or hand, or a **mustard bath**; then even **sponging with hydrant-water** will rapidly produce the desired result. **Spraying cold water on the patient** has been found to be the most effective treatment. The water should not be too cold. For convulsions and tonic spasms **chloroform** is important. Free perspiration should be induced as soon as possible. **Diuretics** act well by assisting the elimination of waste-products. Nux vomica should not be administered, as it may only be synergist to the toxin. **Water** should be given as soon as

possible and **freely administered** until convalescence. John Zahorsky (Pediatrics, No. 4, 1898).

Studies of 92 cases of thermic fever. The best method of applying cold was apparently **rubbing with ice**. In those cases in which there was no decrease in the symptoms corresponding to the fall of temperature **venesection** was found to be of benefit. It was employed in 8 cases, with 4 deaths. The quantity withdrawn varied from 6 to 20 ounces. **Hypodermoclysis** was employed in 28 cases of the severest type, and only 1 died. As, however, the normal saline solution entered the circulation too slowly, **intravenous saline injections** were used in 10 cases, with 4 deaths. No infection occurred. In certain cases not improved by the hypodermic method **venesection and transfusion** may be employed. Lewis and Packard (Amer. Jour. Med. Sciences, Sept., 1902).

With an abnormally high temperature the speedy extraction of heat possibly saves the patient's life, and, the longer such a degree of temperature is allowed to remain, the more grievous and the more permanent the damage to the delicate structures of the cerebral tissues. In some cases, if cold cannot be obtained or applied quickly enough, **bleeding** is imperative, and there can be no question that it has saved lives in these cases. The discredit applied to this therapeutic measure in recent years is undoubtedly due to the fact that it has been misused and employed in cases of heat exhaustion instead of those of true sunstroke.

The application of cold should be continued until the temperature falls to a safe point, that is, to below 105° F. (40.5° C.). If at any time it should rise to 105° F. thereafter the applications of cold should be renewed. However, with a temperature once reduced to 105° F. (40.5° C.), it should not be difficult to keep it down by the use of **veratrine**. This remedy should be given in small doses, say $\frac{1}{32}$ grain (0.00048 Gm.),

well diluted, and repeated every five to thirty minutes.

One contraindication for the use of veratrine is the irritability of the stomach. If this occurs and the need still continues for arterial sedatives, **aconitine** should be substituted in similar doses. **Veratrine** is of special value here, as it is the most powerful eliminant at our command, and sunstroke may be looked upon as acute toxemia. W. F. Waugh (Amer. Jour. Clin. Med., July, 1908).

As excessive loss of water in sweat is the main factor in the development of heatstroke **copious drinking** is important in its prevention. When after profuse perspiration the skin begins to dry off, heatstroke, that is, general arterial anemia, is impending. If relief is not soon obtained the victim becomes unconscious and hovers on the brink of the grave. In treatment, besides combating the high temperature and defective respiration and heart action, it is important to supply more fluid to the organism. This will protect the red corpuscles and prevent further escape of hemoglobin into the blood. That already in the blood should be removed by **venesection**. The writer advises removal of from 150 to 200 Gm. of blood from a vein, followed at once by **infusion of salt solution** through the same hollow needle. The lumen of the needle should be large enough to allow the escape of the morbidly thick venous blood. Senftleben (Berl. klin. Woch., July 1, 1907).

Sometimes after exposure to excessive heat there is twitching of the muscles, and even severe convulsions. When the convulsions occur and continue they may be controlled by a hypodermic injection of $\frac{1}{4}$ grain (0.016 Gm.) of **morphine** with $\frac{1}{150}$ grain (0.0004 Gm.) of **atropine**. If they resist this treatment, the patient may be anesthetized by the administration of **chloroform**, or a rectal enema containing 30 grains (2 Gm.) of **bromide of sodium** and 15 grains (1 Gm.) of **hydrated chloral**

may be administered and repeated, if necessary, after one hour. Editorial (Jour. Amer. Med. Assoc., July 15, 1911).

The remarkable recovery in a few hours from what appeared to be imminent death, on two occasions in a personal case, after the **withdrawal of cerebrospinal fluid**, seemed to point to the fact that the patient was suffering from a meningocortical edema caused by the excessive heat-rays of the sun, and that the fluid was being excreted faster than it could drain away, removal of the excess of pressure causing recovery. A. S. St. John (Brit. Med. Jour., Jan. 27, 1912).

A patient with heat prostration should be treated, in some respects, entirely different from one with sunstroke. Here we often have subnormal temperature, necessitating a **hot bath**. If the temperature is above normal, **sponging with moderately cold water** will soon overcome it, but an ice-bath must not be given. The patient should be kept in a cool place, avoiding constricting clothing about the neck and chest. To overcome the tendency to syncope, **aromatic spirit of ammonia**, **spirit of glonoin**, or inhalations of **amyl nitrite** may be given. **Strychnine**, **digitalis**, **iron**, and a concentrated nourishing diet should be given to combat weakness in convalescence. When recovery is complete, measures to avoid a relapse should be instituted. Israel Bram (Med. Rec., July 27, 1912).

In addition to the old classic treatments, the writer advises the use of **lumbar puncture** not alone because of the similarity between the symptoms of sunstroke and meningitis, but because the cerebrospinal fluid is under increased tension, and in the severer cases it is albuminous and blood-stained with initial polynucleosis, followed later by a persistent lymphocytosis, an indication that the meninges are involved. When used early it lessens the headache and the somnolence. The operation should be repeated until the cerebrospinal

fluid has become normal, macroscopically, microscopically, and chemically. The operation, simple and safe, has been used in the relief and cure of the sequelæ of sunstroke. De Massary, Lian, and Dufour speak highly of the results of this method. Mulot (Amer. Med., July, 1912).

The best means to ward off edema of the brain or lung is by **venesection**; the benefit is often striking after removal of 200 or 300 c.c. Venesection is indicated in the asphyxia form of heatstroke if the stagnation in the venous system and lungs persists longer than one or two hours. A. Hiller (Deut. med. Woch., June 19, 1913).

The treatment of heat exhaustion and heatstroke, though both are due to excessive heat, should be antagonistic. While in heat exhaustion the object should be to raise the vascular tension and cause the blood to return to the cerebrospinal system and the periphery, in heatstroke the aim should be to depress the vascular erethism and relieve the cerebrospinal system, lungs, and all peripheral tissues of the intense congestion to which they are being subjected. It is in *heat exhaustion*, therefore, that **strychnine**, **digitalis**, **aromatic spirit of ammonia**, and other stimulants are indicated. The ice-bath here is an absurd measure; the skin has cooled itself sufficiently by inducing reflexly, through the heat and vasomotor centers, a hypothermia of over 3° F. A **warm bath** is indicated if any is used at all. In a shady, cool place, with the clothing loosened or removed, such a patient will promptly respond to the above stimulants. Conversely, the **ice-bath**—or, better, affusions of ice-water combined with **frictions** until the temperature is reduced to 102° F. (38.9° C.), a procedure which gave O'Dwyer the lowest mortality on record—is the dominant therapeutic factor of *heatstroke*. **Ice-water enemas**, **hypodermoclysis**, and the **ice-cap** are potent adjuvants, while no threatening case should be de-

prived of the most active cerebro-spinal depletant, **lumbar puncture**, which has now received the sanction of several authorities. Editorial (N. Y. Med. Jour., Aug. 9, 1913).

Baruch shows that the mortality rate may be reduced to 6 per cent. by means of **affusions with force**, of ice water, stopped when the temperature falls to 103° F. He contrasts the various methods and mortality. The graduated bath (110° to 72° F.) has a mortality of 41.17 per cent.; the ice pack a mortality of 38.7 per cent.; the cold bath (70° to 50° F.) a mortality of 33.33 per cent.; the needle spray a mortality of 11.5 per cent. As hospitals and tubs are not always at hand, the chief point of interest may be how to reduce the temperature without ice water. The **clothing is removed from the chest and legs**. **Water** is then **sprinkled over the exposed parts of the body** and **evaporation** produced by **waving a coat rhythmically over the face, chest, and legs**. This stimulates the brain and nervous system. When the patient can swallow, **water** (not whisky) is **freely administered**. Editorial (N. Y. Med. Jour., Sept. 19, 1914).

In extreme sudden cases fastening a **towel firmly around the stomach**, **filling the colon with air**, and a **sand bag over the abdomen** may aid hemostasis, with body flat, and legs raised.

C. SUMNER WITHERSTONE,
Philadelphia.

HEMATOLOGY AND SERUM REACTIONS.—By the term *hematology* is meant the aggregate of our knowledge concerning the blood, while *serum reactions* refer to diagnostic tests based upon the examination of the blood-serum for various biological constituents.

The blood is both a tissue and a fluid. It is composed of plasma and blood-corpuscles. The former is made up chiefly of water, with a small percentage of serum albumin, serum globulin, glucose, inorganic salts, fibrinogen, and extractives, and containing in solution small amounts

of oxygen and nitrogen and variable amounts of carbon dioxide. The corpuscles are composed of water, oxyhemoglobin, lecithin, salts, fibrin ferment, blood-plates, hemoconia, and the stroma. The composition of the blood, as given by Simons, is as follows:—

Plasma	520 parts.
Water	477.37 parts.
Albumins	35.88 parts.
Extractives	2.39 parts.
Inorganic salts	4.36 parts.
Corpuscles	480 parts.
Water	276.90 parts.
Oxyhemoglobin	193.90 parts.
Stroma	9.20 parts.

There are two kinds of corpuscles, the red and the white, the former being much more numerous.

METHOD OF OBTAINING A SPECIMEN FOR EXAMINATION.—Before making a puncture for the withdrawal of blood it is best to determine the absence of hemophilia.

The best locations for making the puncture are the lobe of the ear and the finger. In a young child the great toe may be used. The advantages of making the prick in the lobe of the ear are that the patient cannot see what is being done, and that the skin in this place is thin and not very sensitive. The advantages of using the finger are the absence of hairs, and the ability of placing the hand in a convenient position.

The part in which the puncture is to be made should be washed thoroughly with soap and water, then alcohol, and finally ether. The parts should be massaged, or rubbed with a towel previous to the puncture. For making the puncture a Daland, Hagedorn, Francke, or a glover's needle, or the half-point of a new sharp-pointed steel pen, may be used. The instrument used should be thoroughly sterilized by passing it through the flame of a Bunsen burner or alcohol lamp.

After the application of a broad rubber band to the finger of the patient, it is held firmly between the index finger and thumb of the operator and the stab made quickly and fairly deep into the tip. The first drop of blood exuding should be wiped away and the second one used. The part

should not be pinched, but the blood allowed to flow naturally. If the lobe of the ear is used the stab is made into the lower edge parallel to the surface, if lobe is thin; if thick, stab may be made on surface.

Larger quantities of blood may be withdrawn by means of wet cups, or a sterile syringe may be used to withdraw the blood from a dilated vein. Venesection may be done if necessary.

COLOR.—The color of the blood is due to the hemoglobin, an albuminous substance which is found in the red blood corpuscles. It is combined with oxygen in the arterial blood, giving a scarlet-red color to the blood; while in the venous blood there is a mixture of hemoglobin and oxyhemoglobin, giving a bluish color to the blood. The variations in color are due to the relative proportions of oxygen and carbon dioxide in the two types of blood.

Under certain pathological conditions the color of the blood may be changed. In anemia the blood is pale and watery. When there is an excessive number of white corpuscles, as in cases of severe leukemia, the blood may have a milky appearance. In diabetes it is buff-colored. Admixture of blood with water, saline solutions, urea, ether, snake venom, mushroom extract, etc., causes the blood to lose its opacity by dissolving out the hemoglobin from the cells; this is called hemolysis or "laking." Certain poisons also change the color of the blood, as in coal-gas poisoning the blood is cherry-red in color; while in poisoning from potassium chlorate or hydrocyanic acid it has a chocolate hue.

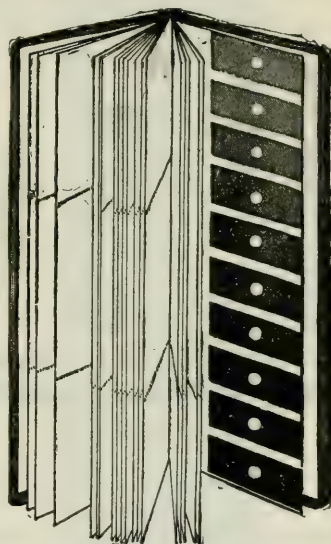
TASTE.—The blood has a salty taste.

ODOR.—The blood has a characteristic odor, which differs in different animals. This odor is due to certain volatile fatty acids; it is accentuated by the addition of concentrated sulphuric acid (Barruel's test).

REACTION.—The blood is alkaline in reaction, due to sodium carbonate and bicarbonate and disodium hydrogen phosphate. The reaction may be determined by the use of litmus paper. This is first moistened with a saturated solution of common salt and is then drawn through

the blood. The red corpuscles are then washed off in the same solution. The alkalinity diminishes rapidly after the blood is shed. This is due to certain acids which form. Normally, the degree of alkalinity varies from 325 to 360 mg. of sodium hydrate for each 100 c.c. of blood. This is determined by titration. There are other methods, such as Davis and Salkowsky's, for obtaining the reaction of the blood, but they are too complicated for the use of the general practitioner.

SPECIFIC GRAVITY.—The normal specific gravity of the blood ranges from



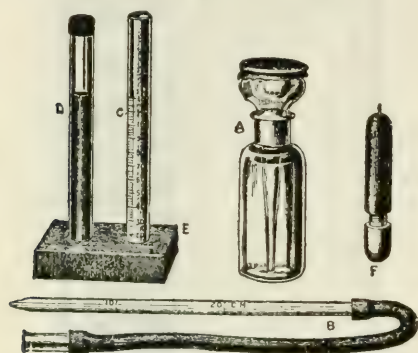
Tallqvist's hemoglobinometer.

1.055 to 1.065, the average being 1.060. Different physiological conditions cause a variation in the specific gravity, as age, sex, exercise, the process of digestion, the amount of hemoglobin, and the time and temperature at which the determinations are made.

Hammerschlag's Method of Determining the Specific Gravity.—Benzol and chloroform are used for this test. The specific gravity of the former is 0.889, and of the latter, 1.526. These two are combined, so that the mixture has a specific gravity of from 1.05 to 1.06. A puncture is made in the finger and a drop of blood is allowed to fall directly into the solution. It is brought into suspension by the addition of either the benzol

or the chloroform and, when it remains absolutely stationary in the center of the perpendicular axis of the solution, the specific gravity of the mixture is taken by means of an hydrometer. The reading will represent the specific gravity of the blood.

ESTIMATION OF THE PERCENTAGE OF HEMOGLOBIN.—There are many kinds of hemoglobinometers in use, and among those most frequently used may be mentioned the Tallqvist, Gower, Sahli, Haldane, Oliver, Gartner, Hayem, Dare, Henocque, Fleischl; the spectrophotometer of Hüfner, the colorimetric double pipette of Hoppe-Seyler, and the



Gower's hemoglobinometer.

methods of Webelthan and of Lange-meister, for laboratory use.

Tallqvist's Method.—Although less accurate than the other methods, this method is frequently used. The instrument consists of a booklet and a color scale and is most convenient, as it can be carried in the pocket. After making the puncture in the finger, a drop of blood is allowed to fall on one of the leaves (of filter paper) from the booklet. This is then drawn along the color scale until the drop of blood and one of the shades correspond and the percentage is read from the color scale.

The comparison between the blood droplet and the color scale must be made at once, as changes take place in the hemoglobin when dried.

Gower's Method.—This apparatus consists of two tubes, a graduated pipette, and a dropping bottle. The mixing test-tube is graduated from 5 up to

120, so that when 20 c.mm. of normal blood are diluted with water up to the 100 mark with water the color should exactly correspond with that of the contents of the other tube, which contains a glycerin jelly tinted with picrocarmine in such a way as to represent the color of the normal blood.

A small quantity of water is placed in the graduated mixing tube, and a few drops are drawn into the graduated pipette. The puncture is made, after having thoroughly cleansed the finger with alcohol, then ether, and wiped away the first drop of blood. The blood is then drawn up into the graduated pipette to the 20 c.mm. mark. The tip of the pipette is placed in the water in the bottom of the graduated tube, the blood blown out and allowed to settle to the bottom. The pipette is washed out several times by drawing up the supernatant fluid and blowing it out again. The blood and water are then thoroughly mixed by shaking.

The two tubes are now placed side by side against a piece of white paper held in the light, and the colors compared. Water is added, drop by drop, to the diluted blood, mixing after each addition, until the color in the two tubes exactly corresponds. The percentage of hemoglobin is expressed by reading off the height of the column of diluted blood.

Sahli's Method.—This method is similar to the one just described. The standard tube contains a solution of acid hematin in glycerin and water, corresponding to a 1 per cent. solution of normal blood, and has a brown color. A decinormal solution of hydrochloric acid is used to convert the hemoglobin of the blood into acid hematin. A small amount of hydrochloric acid is placed in the graduated tube and the blood drawn up. This will turn brown. About one-half hour is allowed to pass; then the diluted acid is added until the color of the mixture in the graduated tube exactly corresponds with that of the standard tube. The percentage of hemoglobin is then estimated.

Fleischl's hemoglobinometer consists of a cylindrical cell for holding the prepared blood, a graduated wedge-shaped piece of colored glass with which to compare the

solution of blood, a stand with rack and pinion and a circular opening into which the cell is placed, and a capillary tube for measuring the quantity of blood required.

1. The cell is a cylindrical metallic chamber, divided by a fixed partition into two equal compartments, open at the top, and closed at the bottom by a base of glass. One of these compartments is to be filled with distilled water, the other with the proper quantity of blood dissolved in distilled water.

2. The colored glass wedge, tinted with Cassius's golden purple, is fitted to a metal frame, so that it can be adjusted in the stand and moved from side to side by the rack and pinion. When in position the glass wedge moves directly beneath that compartment of the cell which contains the distilled water, thus enabling one to compare the color of the glass with that of the dissolved blood, which fills the adjoining compartment of the cell. The glass wedge is graduated from 1 to 100, the figures representing the percentage of hemoglobin in the specimen of blood as compared to normal blood containing 13.7 per cent. hemoglobin. Thus, $100:13.7::p:x$, where p represents the reading on the scale and x the corresponding amount of hemoglobin.

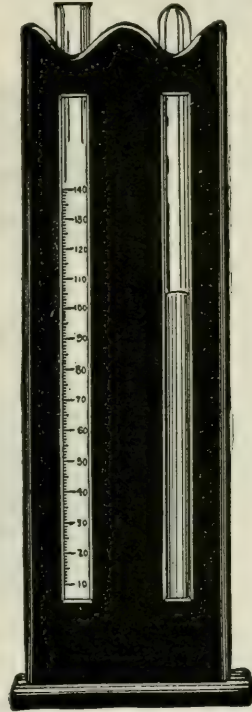
3. The stand, besides having a support for the glass wedge and frame, has a white gypsum mirror below, which furnishes the diffused light required in the test, and a circular recess on top for the reception of the cell.

4. The capillary tubes are mounted in metal handles, and are carefully adjusted to hold the proper quantity of blood. The size of these tubes varies, and the capacity of each is stamped on the handle. Each tube must be used only with an instrument bearing the same number stamped thereon.

Technique.—The capillary tube is cleaned, first, by using distilled water, then ether, and dried by forcing air through it. Both compartments of the cylindrical chamber are filled three-fourths with distilled water. The puncture having been made, with previous cleansing and drying of the part, in the lobe of the ear or the tip of the finger, and a small drop of blood having appeared, one end of the capillary tube

is applied to the apex of the drop (not immersed in it), whereupon the tube will instantly fill with blood.

Any blood clinging to the sides of the tube must be removed. This measured quantity of blood is then dissolved in one chamber of the cylindrical vessel by plunging the tube into the water, moving it back and forth in the direction of its long axis, and finally rinsing with a few drops of distilled water. A medicine drop-



Sahli's hemometer. (Greene.)

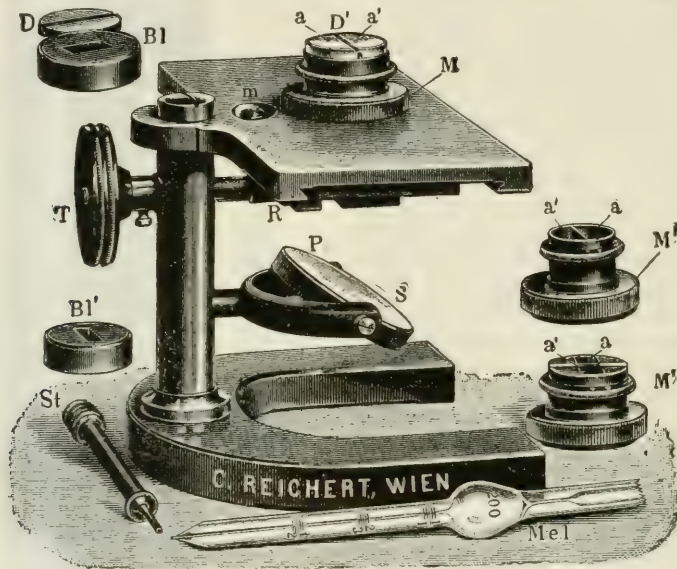
per with a fine point is then used for completing the filling of both compartments. Do not stir, as that might cause an overflow.

The cell should be in position on the stand, with the wedge in place, before completing the filling. The color of the glass wedge is intended for use with yellow light, which is derived from a candleflame, preferably large and placed within 6 inches of the reflector. In reading the percentage use a tube 8 to 10 inches long and $1\frac{1}{2}$ inches in diameter, preferably blackened on the inside, placing it on the stand surrounding the vessel

to cut off any overhead light. Set the stand so that the partition of the cell is in line with the vertical axis of the eye, and adjust the candle and reflector to give the best possible light. Closing the eye on the side toward the candle, apply the other to the tube, and turn the screw quickly until the color of the two compartments appears the same. Rest the eye for a few seconds and look again. Repeat until, to the rested eye, the colors are identical. Then read off the percent-

construction, but different in its calibration, and the diluent used is 0.1 per cent. sodium carbonate solution, which dissolves the stromata of the red cells and furnishes a clear solution.

An estimation of the percentage of hemoglobin is very important in some conditions. Both the presence and degree of an anemia may be estimated by the estimation of the hemoglobin. The estimation of the hemoglobin may also show the presence of a severe septic condition



Fleischl-Miescher hemometer. (Webster.)

R, stage; *T*, muller head, which moves the color scale; *m*, opening in stage, through which the instrument is read; *M*, mixing cell; *D'*, cover glass; *D*, cap; *PS*, gypsum mirror, from which the light is reflected; *Mel*, diluting pipette.

age. Inasmuch as high percentages of hemoglobin are more easily read than low ones, in cases where a low percentage is known to exist it is well to take two or three times the usual amount of blood, using a dry tube each time, and calculating the percentage accordingly.

A later form of this apparatus, devised by Miescher, has the same stand and same scale principle, although the scale is standardized differently and graduated on a different basis. It differs in the method of measuring and diluting the blood, in the form of the comparison chamber, and in the meaning of the graduation of the scale. The diluting pipette is similar in

in which there is usually a marked and rapid fall of the hemoglobin content. Again, a decrease in the percentage of hemoglobin from day to day may indicate the presence of hemorrhage. In malaria there is also a decrease in the percentage of hemoglobin, and the fall is sudden and rapid in the early stages.

A relative diminution of hemoglobin is known as oligochromemia or as achrocythemia, and is usually associated with a decrease in the number of erythrocytes (oligocythemia); in chlorosis, however, the diminution of hemoglobin is an absolute reduction, each cell showing less hemoglobin.

COLOR-INDEX.—By this is meant the percentage of hemoglobin present in each red cell. It is found by dividing the percentage of hemoglobin by the percentage of red corpuscles.

There may be a relative or absolute change in the amount of hemoglobin present in each red cell in different pathological conditions.

TOTAL VOLUME OF THE BLOOD.

—By the older methods the quantity of blood in the body has been estimated as equal to one-thirteenth of the body weight.

By the more recently described method of Haldane and Smith the amount has been found to range between one-thirtieth and one-sixteenth of the body weight, the volume being proportionately less in the obese.

VISCOSITY OF THE BLOOD.—As coagulation proceeds in freshly drawn blood the previous greasy feeling is replaced by a stickiness, which is dependent in large degree upon the cellular content. Cold increases the viscosity, while heat diminishes it.

COAGULATION OF THE BLOOD.

See COAGULABILITY OF THE BLOOD.

ESTIMATION OF THE CORPUSCLES.—A special apparatus is necessary for the estimation of the corpuscles. The best apparatus for this purpose is the Thoma-Zeiss hemocytometer. This consists of two pipettes, for diluting the blood, and a counting chamber.

Each pipette has a long, graduated stem, above which is a small bulb containing a little glass ball. The stem of the pipette is divided into 10 parts by transverse lines. On the one for counting the red blood-cells (erythrocytes) the middle line is marked 0.05, and the upper end near the bulb, 1. The line just above the bulb is marked 1.01.

The pipette for diluting the white blood-cells (leucocytes) is of larger caliber than that used for the erythrocytes, and the line above the glass bulb is marked 11.

The counting chamber consists of a thick, flat plate of glass, in the center of which is cemented a square piece of glass having a circular opening in its center. A small circular disc is cemented to the glass slide, so that it is in the center of

the opening in the square plate. This disc is just $\frac{1}{10}$ mm. thinner than the square plate and the edges do not come into contact with the margins of the circular opening, thus forming a "moat" around the circular disc.

The depth of the chamber, formed by the application of a special cover glass over the circular opening, is exactly $\frac{1}{10}$ mm. Fine microscopic lines divide the center of the floor of this chamber into minute squares. There are 16 large squares separated from each other by double ruled lines, and each large square is again divided into 16 smaller squares. There are, therefore, 256 small squares, and if we count the small squares between the large squares there is a total of 400 small squares. The space between each square and the cover glass is exactly $\frac{1}{10}$ mm. in depth, $\frac{1}{20}$ mm. in length, and $\frac{1}{20}$ mm. in width, so that its cubic capacity is $\frac{1}{4000}$ c.mm.

Diluting Fluids.—For the proper examination of the blood, it must be diluted with a solution which will not only prevent coagulation and hemolysis, but will preserve the corpuscles intact.

If both leucocytes and erythrocytes are counted in the same specimen only one diluting fluid is necessary. Toisson's solution is here given:—

Sodium chloride	1 Gm.
Sodium sulphate	8 Gm.
Neutral glycerin	30 c.c.
Distilled water	160 c.c.
Methyl violet, 5B	0.025 Gm.

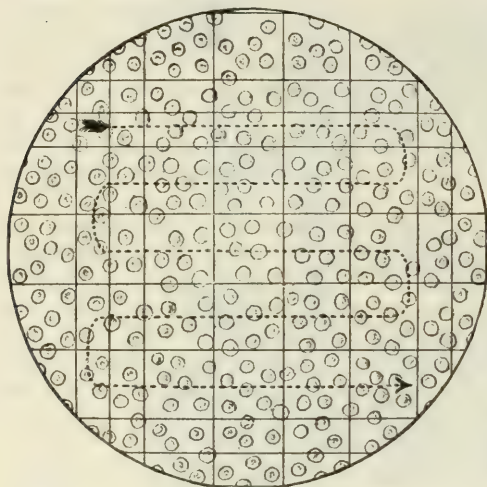
When used, a few minutes only are necessary to stain the white blood-corpuscles so that they may be easily distinguished from the red cells. Occasionally this fluid hemolyzes the red cells and thus invalidates the count. It is, moreover, easily infected with yeast spores, which develop rapidly in it; hence, the fluid should always be filtered before use, and, as each filtration weakens it, it gradually becomes useless and must be replaced by a freshly made solution.

If the red and the white corpuscles are to be counted separately then two diluting fluids are necessary. Hayem's solution may be used when counting the red blood-cells. This contains:—

Mercuric chloride	0.5 Gm.
Sodium sulphate	5.0 Gm.
Sodium chloride	1.0 Gm.
Distilled water	200.0 c.c.

For diluting the blood for counting the white blood-cells a 0.3 to 0.5 per cent. solution of glacial acetic acid may be used, to which is added gentian violet to bring out the white cells more clearly. This solution destroys the red cells, leaving only the white; it must be freshly prepared.

Technique.—After making the puncture in the finger or ear the blood is drawn up



Da Costa's plan for the counting of corpuscles.
(Webster.)

in the pipette to the mark 0.5 or 1, according to the dilution one wishes to have. The tip of the pipette is carefully wiped free of blood with the fingers and is then immersed in the diluting fluid, which is drawn up into the tubes by suction to the mark 1.01. After having drawn up the diluting fluid, the pipette is removed, the fingers placed over each end of the pipette, and it is then thoroughly shaken so that the blood and diluting fluid are thoroughly mixed.

If the estimation is not to be made immediately, remove the small rubber tube from the pipette and stretch a rubber band over both ends so that both openings are covered. All examinations should be made within a few hours.

Thoroughly clean both slide and cover

glass with water and then dry. Do not use alcohol or xylol, as these are liable to dissolve the cement and thus loosen the small glass plate and disc.

Blow out the portion of diluting fluid in the capillary part of the pipette and wipe the tip. The next drop of the diluted blood is allowed to fall in the center of the small circular disc. The cover-glass is very gently applied and when in place gentle pressure is made at the corners. Should any of the diluted blood run over the edge of the circular disc into the surrounding "moat" or should air bubbles be present the slide must be cleaned and the whole procedure repeated. Allow a few minutes to pass before beginning to count, so that the corpuscles may settle to the bottom of the chamber.

After placing the slide under the microscope examine first with the low power. Having located the small squares and gotten them into the center of the field turn on the high power and screw it downward until it almost touches the top of the cover glass. Looking down the microscope, focus slowly upward until the lines come into view. Should the lines be very indistinct, they may be brought out by rubbing gently with a soft lead pencil before dropping on the diluted blood.

Counting the Erythrocytes.—Move the slide so that one corner of the ruled area is under the eye. It is preferable to begin at the left upper corner. One hundred small squares are to be counted. There are 16 small squares in 1 large square, so that 6 large squares and then 4 small squares should be counted. It is best to count the squares in different parts of the ruled area and thus be sure that 1 large square is not counted twice.

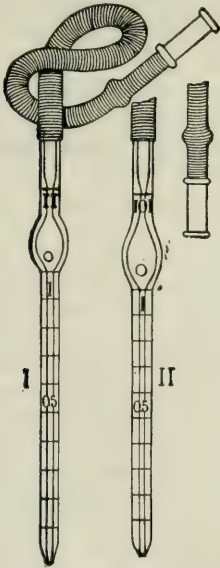
Begin by counting the corpuscles lying in the center of the small square and then those on the lines. It is best to count those corpuscles lying on the upper and left-hand lines as being in the square, disregarding those on the lower and right-hand lines.

The leucocytes are distinguished because they are more refractile and are slightly tinged if a stain has been used in the diluting fluid.

Calculation.—The average number of corpuscles in each square is first gotten by adding together the corpuscles in all the squares counted, and then dividing by the number of squares counted. The capacity of one square is $\frac{1}{4000}$ c.mm. If the dilution used is 1:100, the average number of corpuscles found in each square is really contained in $\frac{1}{4000}$ of $\frac{1}{100}$ of undiluted blood; therefore, to determine the number of corpuscles in 1 c.mm. of undiluted blood the average number of cells per square is multiplied by 100, and that product again by 4000.

Example.—Suppose after counting 100 squares the total is 1500 corpuscles, then the average per square is 15. If the dilution was 1 in 100 multiply by 100 and that product by 4000, which equals 6,000,000. This would be the number of red corpuscles in 1 c.mm. of undiluted blood, a normal count.

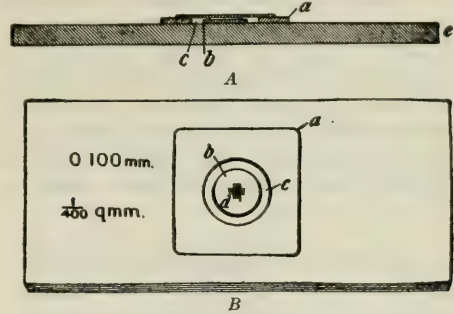
Counting of Leucocytes.—The white cells are best counted in the same speci-



I, leucocytometer; II, erythrocytometer of Thoma-Zeiss hemocytometer.

men as the red, but in order to count enough leucocytes to insure accuracy in the specimen prepared for counting the red cells a much larger field must be traversed than is outlined in the ordinary Thoma counting chamber. This larger

field is secured in a special chamber originated by Zappert by which the original ruling is so modified that a counting surface of 9 sq. mm. is afforded. This modification has been improved by Türk in such a way that the 4 large corner squares, each of 1 sq. mm., are sub-



Counting chamber of the Thoma-Zeiss hemocytometer. A, profile view; B, face view; a, wall of cell; b, central disc; c, groove about disc; d, ruled surface.

divided into 16 smaller squares, each of which is equal in area to the total 25 smallest squares of the Thoma chamber. The 16 central squares are used in counting the erythrocytes, while the entire area may be used in counting the leucocytes. It is usually sufficient to count the white cells in a single drop, but for accuracy 3 or even 4 drops had better be examined. The calculation by this method is very simple. As the entire ruled area of the Türk chamber covers an area of 9 sq. mm., each equal to the central area used in counting the red cells, we have the equivalent of 3600 small squares in the ruled surface. Multiply this figure by the number of drops used, to obtain the total number of small squares covered by the count. Thus, if 108 leucocytes were counted in 2 drops (7200 small squares) and the dilution was 100 then we have the equation

$$\frac{108 \times 100 \times 4000}{7200} = 6000.$$

We may arrive at the result in another way by considering each square millimeter of the surface of the Türk chamber as a unit. If, then, the number of cells counted in 2 drops (18 units) be 108, divide this number by the number of units counted,

18, and multiply the result by 10 (the cubic contents of each unit) and then by the dilution (100)—

$$\frac{108 \times 10 \times 100}{18} = 6000.$$

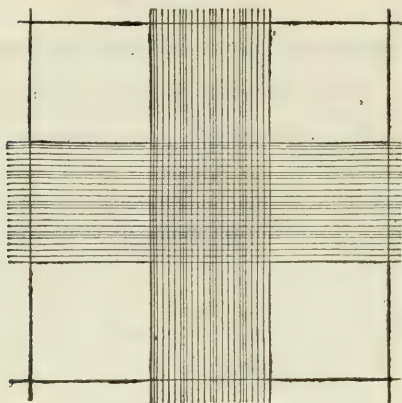
It may be found desirable in counting the leucocytes to use the special leucocytometer supplied with the Thoma-Zeiss apparatus, as this gives a lower dilution and therefore more leucocytes to the surface counted. In using this pipette, the blood is drawn to the mark 1 and the diluent (1 per cent. acetic acid) added to

pumped or blown through the pipette until it is thoroughly dry.

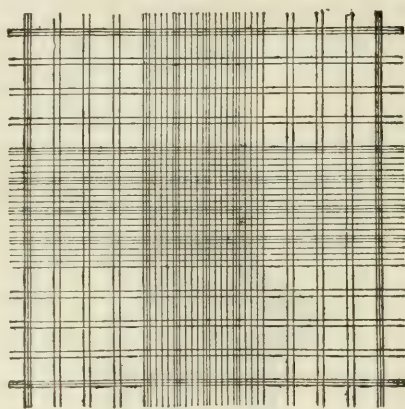
If the blood has coagulated within the pipette, the tube may be placed in a test-tube containing hydrochloric acid and allowed to remain there for twenty-four hours. It should then be cleaned in the same way mentioned above.

DIFFERENTIAL BLOOD-COUNT.—

The cover-glasses used for making a blood-smear should be square, thin, and thoroughly cleansed, first with soap and water, and then with ether. They may then be kept in alcohol, and wiped dry with tissue paper when they are to be



Zappert ruling.



Türk's ruling.

the mark 11. This diluent destroys the red cells and brings out the leucocytes. If a Türk chamber is used, a count of at least 250 is necessary, better more. The calculation is the same as before. If 300 cells were counted in 5 sq. mm. of ruled surface, the dilution being 10, we have

$$\frac{300 \times 10 \times 10}{5} = 6000.$$

The diluent should be fresh and free from yeast spores.

After making a blood-count the pipette used should be cleaned immediately. All fluid in the tube should be blown out and distilled water then drawn up into the pipette. This is blown out and absolute alcohol drawn in. This is in turn expelled and ether drawn up into the tube. The ether is finally blown out and air

used. This is to insure the proper spreading of the blood between the surfaces of the glasses, as the presence of any fat or dust particles will prevent it.

A cover-glass is taken between the thumb and index finger of the one hand, it being held by the opposite corners. A second cover-glass is taken between the same fingers of the other hand, but is held by the adjacent corners.

The part from which the blood is to be taken is prepared and the puncture made in the manner already described. The first drop of blood is wiped away. The center of the cover-glass is allowed to touch the upper surface of the second drop of blood. The cover-glass, held in the manner already described, is now allowed to fall on the glass containing the drop of blood. If the operation is properly done and the drop of blood the right

size, the blood will spread out between the two cover-glasses and retain its circular shape. These two cover-glasses are then drawn or slid apart in a line parallel to the plane of their surfaces—never lifted apart—and two uniform smears result.

Instead of the cover-glasses a glass slide and a piece of stiff cigarette paper may be used. The technique is much the same. The cigarette paper is held between the thumb and middle finger on the under surface and the index finger on the upper surface, the latter forming a little gutter in the paper. The lower edge of the cigarette paper is dipped into and takes up a portion of the drop of blood. The paper is then straightened out on the glass slide and drawn along its upper surface. This will make a uniform smear if properly done.

Two glass slides may be used in a similar way to the method just described.

Method of Fixation.—Before any method of fixation is used the smear should be allowed to dry in the open air. If one of the Romanowsky stains is used no previous fixation is necessary, the fixation being done by the methyl alcohol employed as a solvent for the various stains.

1. Smears may be fixed by *heat*. After being air-dried they are exposed to a temperature of from 110° to 150° C. (230° to 300° F.), by placing the slides in a dry-air sterilizer, for about five minutes. Another method is to place the slides on a strip of copper which has been heated by a Bunsen burner to a maximum degree. In this case one-half hour is required for fixation. Fixation by heat is the best method, but the most difficult to use. It is the only reliable one if we wish to use Ehrlich's triple stain.

2. Smears may be fixed by placing them in a mixture of equal parts of *absolute alcohol and ether*, and allowing them to remain for from one-half to two hours; after fixation allow the fixative to evaporate or wash with water and dry (Nikiforoff's method).

3. Smears may be fixed in a 1 per cent. solution of *formaldehyde* in 95 per cent. alcohol. One minute suffices for fixation.

4. Finally, smears may be fixed by *absolute alcohol*, allowing from five min-

utes to one hour for fixation; the former time when an alcoholic stain is used, and the longer time for a watery or alkaline one.

Methyl alcohol, C. P., fixes a smear in from three to five minutes. It is a great favorite and gives beautiful specimens. A longer fixation does no harm.

Methods of Staining.—Two varieties of stains are in use—the basic and the acid. Examples of the former are methylene blue, hematoxylin, basic fuchsin, methyl green, carmine, and toluidin. In these the staining property exists in the basic radicle of the salt. They include all the stains used for staining bacteria, and they all color the nuclei of cells. Examples of the acid stains are eosin, acid fuchsin, orange G, and picrate of potash. Here the staining property lies in the acid radicle of the salt.

Eosin and Methylene-blue Stain.—*Technique.*—The two stains are used separately. The smear is first fixed in pure methyl alcohol for three minutes, and is then immersed in a 0.5 per cent. alcoholic (70 per cent. alcohol) solution of Grüber's "french pure" eosin for from three to five minutes. The smear is then gently washed in distilled water, and dried between filter-paper.

The specimen is now placed in a well-mixed and carefully measured solution of 20 drops of a 0.0025 per cent. aqueous solution of methylene blue (B. pat.) and 10 drops of the above eosin solution for from one-half to one minute, then washed quickly with distilled water, and dried at once between filter-paper or over the flame (Müllern's method).

This method stains the erythrocytes a bright-red color. The nuclei of the different varieties of leucocytes are stained varying shades of blue, while the protoplasm is of a very pale blue color. The eosinophile and neutrophile granules are of a bright-pink to bright-red color, the neutrophiles being distinguished from the eosinophiles by their smaller size. The nuclei, mast-cell granules, bodies of the lymphocytes, blood-platelets, malarial organisms, trypanosomes, and filaria are of varying shades of blue.

Eosin-hematoxylin Stain.—This stain is specially adapted to specimens in which

we wish to study the nuclear structures. By its use the nuclei are beautifully stained, revealing details of structure, karyokinetic figures, and pycnotic qualities, as well as the basophile granules of both erythrocytes and leucocytes. The solutions required are a 0.5 per cent. solution of Grüber's blood eosin in 70 per cent. alcohol or a 0.5 per cent. solution of Grüber's "french pure" eosin in 70 per cent. alcohol, and *Delafield's hematoxylin solution*, which is composed of:—

Hematoxylin crystals	4 Gm.
Alcohol (absolute)	25 c.c.
Ammonium alum crystals, C. P.	52 Gm.
Distilled water	400 c.c.
Glycerin, C. P.	100 c.c.
Methyl alcohol, C. P. ...	100 c.c.

Triturate the hematoxylin crystals with the alcohol until they are dissolved and place the solution in a loosely corked bottle, allowing it to stand exposed to the light for four days. Dissolve the ammonium-alum in the water and allow it to stand exposed in the same way for four days. At the end of this time mix the two solutions, shake thoroughly, and filter at the end of three hours. Add the glycerin and methyl alcohol to the filtrate and allow this to stand overnight. Filter the mixture, place it in a clear bottle, and allow it to ripen, exposed to the light for six weeks, when it is ready for use.

Technique.—Stain the specimen with the eosin solution for one-half minute, and wash in water. Without drying place the slide in the hematoxylin solution for from one to three minutes, the time varying with the particular stain and with the experience of the worker. Wash with water, dry, and mount. This stain does not give as good results as the eosin-methylene-blue method, but is preferable for the study of nuclear structures (Webster).

Wright's Stain.—To a 0.5 per cent. solution of sodium bicarbonate in distilled water add 1 per cent. by weight of Grüber's medicinal methylene blue (any of the varieties of the dye may be used). Place the alkaline mixture in an Erlenmeyer flask and steam in an Arnold

sterilizer for one hour, counting from the time steam appears. This process develops the polychromatic powers of the alkaline solution of methylene blue and increases its value as a nuclear and granular stain. On cooling, the steamed solution is poured into a large evaporating dish and to it is added, with constant stirring, enough of a 0.1 per cent. aqueous solution of Grüber's yellow water-soluble eosin to change the color from blue to purple and to form a metallic luster on the surface. This will require about 500 c.c. of the eosin solution for every 100 c.c. of the methylene-blue solution. The resulting black granules contain the active principles of the stain. Collect the precipitate on a filter and allow it to dry, being careful not to wash it. When thoroughly dry make up a 0.3 per cent. solution of this precipitate in pure methyl alcohol. This will require some time and stirring of the mixture, as the precipitate does not dissolve easily. Filter the solution and add to the filtrate 25 per cent. of its volume of methyl alcohol to dilute the stain and lessen its tendency to become precipitated during the staining process.

Technique.—The air-dried films are covered with the stain for one minute; without washing off the stain add to it, drop by drop, water until the mixture becomes semitranslucent and a reddish tinge becomes visible at the edges of the slide or cover-glass; 8 or 10 drops of water will usually be enough. This diluted stain is then allowed to act for two to five minutes, after which it is washed off with distilled water, the blood-film now appearing of a deep blue or purple color. Immerse the slide, stained side downward, in a dish of distilled water, to develop the differential staining properties of the various elements by decolorizing the overstained specimen. This process is complete, as a rule, in from three to five minutes, but the experience of the worker, with any particular specimen, may suggest longer decolorization. The films will now appear reddish in color. When the desired degree of decolorization has occurred, dry the specimen quickly between filter-papers, mount if desired, and examine first with the low-power lens to

observe the staining effects, and then with the high-power lens for more minute study. When searching for malarial parasites, the decolorization would better be of short duration, as the chromatin suffers to a great extent in this process.

Effects.—The red cells colored by this stain are either orange or pink (depending on the time of decolorization), nuclei of leucocytes blue or dark lilac, neutrophile granules lilac, eosinophile granules red or pink, fine basophile granules deep blue, large mast-cell granules purple, protoplasm of the lymphocytes robin-egg blue, blood-plates deep blue or purple; bacteria, malarial and other parasites blue, the chromatin element varying from lilac to ruby-red and black. Polychromatophilia and granular degenerations are well shown, the granules being blue. This stain is much used in studying lymphocytes, mast cells, blood-plates, and the details of the malarial organism, but the granules of the leucocytes are not always sharply differentiated. Webster finds this stain well adapted for making a differential count, as it shows clearly the characteristics of the various types of leucocytes. Webster recommends this stain as a most serviceable one for routine work.

Giemsa's Stain.—Giemsa uses the pure staining substance extracted from the polychrome methylene blue, the methylene azure, making the stain a pure chromatin one. The formula is:—

Azure II	3.0 Gm.
Eosin, B. A.	0.8 Gm.
Glycerin, C. P.	250.0 c.c.
Methyl alcohol, C. P. .	250.0 c.c.

The dyes are dissolved in the alcohol by grinding, and the glycerin is then added. It is generally best to buy this stain ready prepared.

Technique.—The films are fixed in methyl alcohol, stained for five minutes in a mixture of 14 drops of the stain to 10 c.c. of distilled water, washed in water, dried, and mounted. The basic stain may be intensified by adding a trace of sodium carbonate to the distilled water first used. If the films are to be kept, the specimen should be stained on the slide, avoiding unnecessary mounting, for the reason that oil of cedar will bleach these

specimens rapidly. Avoid the action of strong light on these stained films for any length of time, as it causes rapid fading of the stain.

Effects.—These are similar to those of the Wright stain, except that the neutrophile granules are usually not so clearly brought out. For the study of the malarial organism and of smears kept long before being stained, this stain is especially good, as by its use the diffuse plasma staining does not occur.

Ehrlich's Triple Stain.—This stain is a mixture of methyl green, acid fuchsin, and orange G in alcohol, glycerin, and water. As it is difficult to prepare, it should be purchased ready made.

Technique.—The smear is fixed by heat, and a few drops of the stain placed upon it and allowed to remain for from one to ten minutes. It is then washed in distilled water, dried between filter-papers, and mounted.

Effects.—The erythrocytes are stained buff or orange, and the eosinophiles a crimson or bright red. The nuclei of the leucocytes take a dark-green stain, those of the normoblasts black, the neutrophile granules a lilac (occasionally of a reddish tinge). It is a poor nuclear stain, does not show the structure of normal mononuclear leucocytes, does not stain the basophile granules, nor the malarial or other parasites (Webster).

Romanowsky's Polychrome Methylene-blue Stains.—Romanowsky found that when aqueous solutions of eosin and methylene blue were mixed, an insoluble precipitate (methylene azure) was formed, which possessed new staining properties—the chromatin substance of malarial organisms was stained a beautiful red. In the preparation of these polychrome stains the pure methylene azure and eosin are not used, but solutions of methylene blue containing a variable amount of methylene azure to which eosin is then added. The Jenner, Leishman, Giemsa, and Wright stains are of this variety.

Jenner's Stain.—This is a methyl alcohol solution of the isolated precipitate (methyl azure or methylene-blue eosinate). It lacks the red chromatin staining element. This stain should be bought ready prepared.

Technique.—With this stain, fixation is unnecessary. The smear is dried, and a few drops of the stain are placed on it, and allowed to remain from one to three minutes, when it is washed off with distilled water. The smear is then dried and mounted.

Effects.—The erythrocytes and eosinophile granules are stained red, the nuclei blue, and the basophilic granules violet. Malarial organisms are stained blue. Emery suggests the use of this stain for the detection of bacteria.

Leishman's Stain.—This is a modified Romanowsky polychrome stain.

Technique.—Fixation is unnecessary. A few drops of the stain are allowed to fall on the smear and remain about two minutes; a couple of drops of distilled water are then added and left for two or three minutes longer. Then wash, dry, and mount the preparation.

Effects.—The erythrocytes are stained a pale pink and become slightly transparent. The protoplasm of the leucocytes is either colorless in the polynuclear variety, or pale blue in the mononuclear and lymphocytes, while the nuclei of the leucocytes have a ruby-red color. The eosinophiles are stained red.

This is one of the best stains to use when working with parasitic organisms. The nuclei of parasitic protozoa and malarial organisms are stained a bright red.

EXAMINATION OF BLOOD-SMEARS.—**Technique.**—The counting of blood-cells in fixed and stained blood-smears is easily and most satisfactorily done if there is a movable or a mechanical stage on the microscope. The slide is placed in position on the stage, the $\frac{1}{6}$ or $\frac{1}{4}$ inch lens used, and a field at one end of the smear located. The slide is moved from end to end across the stage of the microscope, a new field is then located, and the slide moved back again.

The different varieties of leucocytes are noted and a record kept as they appear one by one. At least 200 and preferably 500 leucocytes should be counted. After having counted the required number the total of each variety should be made and then the percentage of each may be easily calculated.

While counting the leucocytes the character, size, shape, and staining properties of the red cells should be observed. Any other contents of the specimen should also be noted.

DIFFERENTIAL LEUCOCYTIC COUNT.—By this we mean the counting of the different forms of the leucocytes in the stained smear, and the expression of the numbers found in terms of percentage. We note here the principal varieties of leucocytes.

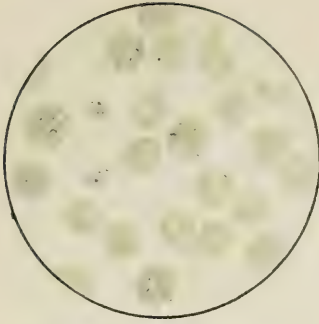
Polynuclear Leucocytes.—These are rather large cells and have an irregularly shaped nucleus. The protoplasm of the cell contains small granules to which the name neutrophile granules is often given. These granules are stained pink when Jenner's or the eosin and methylene-blue method is used, while they assume a coppery color when Ehrlich's method is used. In the normal blood 65 to 70 per cent. of the leucocytes are of this variety.

Under many diseased conditions these cells are increased in number, either relatively or absolutely. In sepsis there is a relative increase in the number of these cells, while the leucocyte count may be normal or diminished. This condition may also be present in malignant disease.

Lymphocytes.—These cells are rather small and contain a single, usually circular nucleus, which almost entirely fills the cell, there being only a narrow band of protoplasm around it. Both nucleus and protoplasm take the blue stain, but the former is more deeply stained than the latter. In normal blood these cells form from 24 to 28 per cent. of the leucocytes.

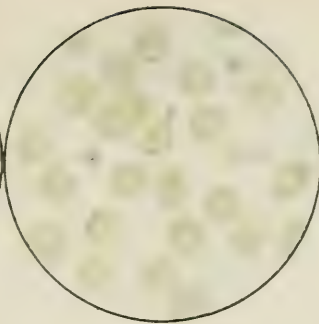
Under pathological conditions these cells may be increased (lymphocytosis) or diminished in number. In certain conditions, as pernicious anemia, splenic anemia, typhoid fever, and Hodgkin's disease, the cells are increased in number, while the total leucocyte count is either normal or lowered; while in infancy and many infantile diseases, they are increased, with a total high count.

Large Mononuclear Leucocytes.—These cells are much larger than the red blood-cells and contain a small nucleus, with a comparatively large amount of protoplasm surrounding it. Both nucleus and



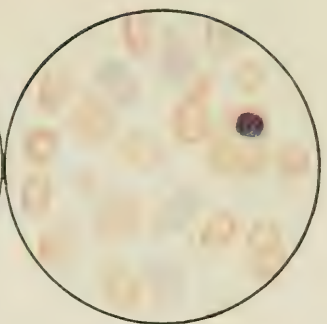
SECONDARY ANEMIA.

Erythrocytes reduced in number; pale, owing to deficiency of hemoglobin. Crenated cells, often caused by evaporation of specimen. Poikilocytes. Pear- and bottle- shaped cells.



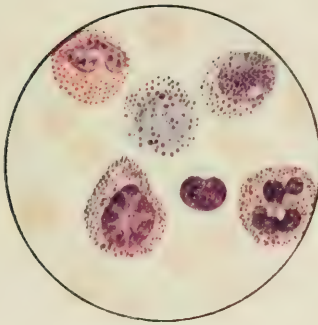
CHLOROSIS.

Marked pallor of erythrocytes, owing to pronounced deficiency of hemoglobin. Poikilocytes when disease pronounced. Blood-platelets. Pear- and bottle- shaped cells.



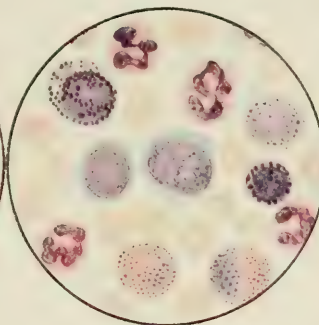
PERNICIOUS ANEMIA.

Erythrocytes highly colored, some more so than others, owing to irregular distribution of hemoglobin, and irregular in shape. Megaloblasts, megalocytes, and microcytes.



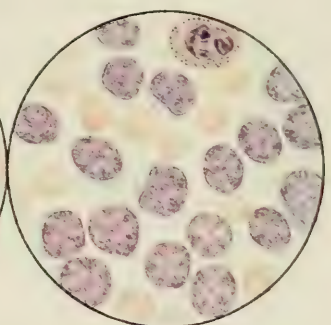
HODGKIN'S DISEASE.

Advanced case; leucocytosis of various forms, but lymphocytes usually predominate. Low color index, owing to deficiency of hemoglobin.



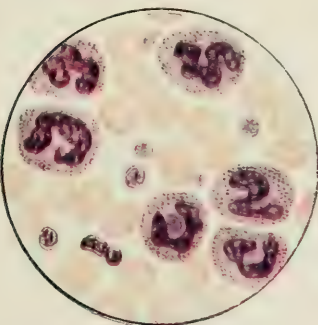
MYELOGENOUS LEUCOCYTHEMIA OR LEUKEMIA.

Very high leucocytosis of all varieties, especially polymorphonuclears and eosinophiles. Basophilic myelocytes with granulations.



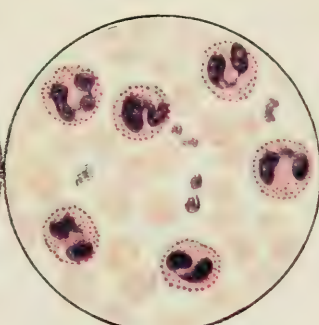
LYMPHATIC LEUCOCYTHEMIA OR LEUKEMIA.

Leucocytosis, but mainly of lymphocytes larger than those of normal blood and probably immature. Secondary anemia also present, as a rule.



NEUTROPHILE LEUCOCYTOSIS.

Marked relative increase of the polymorphonuclear cells, which are densely granular. Increase of blood-platelets.



EOSINOPHILE LEUCOCYTOSIS.

Marked relative increase of eosinophiles somewhat smaller than the usual type. Increase of blood-platelets.



LEAD POISONING.

Presence of granular erythrocytes, which vary in size and show polychromatophilia. Increase of blood-platelets.

BLOOD-PICTURE IN DIFFERENT DISEASES. (Sajous.)

Finer details of cells from Schleip's Atlas, Rebman's Amer. Ed.

protoplasm take the blue stain, the former being deeply and the latter very faintly stained. Of the total leucocytes they form, in normal blood, from 1 to 4 per cent.

These cells may be increased or diminished in number under a few pathological conditions.

Eosinophiles.—These cells are about the same size as the polynuclear variety and have an irregularly shaped nucleus. The protoplasm contains many granules, which stain brightly with the eosin. They form, in normal blood, from 1 to 4 per cent. of all the leucocytes.

Under many diseased conditions there is an increase in the number of these cells and this is especially found in some of the parasitic diseases. In trichinosis the eosinophile count may be as high as 60, or even 80, per cent. Again, in ankylostomiasis there may be either a moderate or high eosinophilia. This is also the case in hydatid disease.

Myelocytes.—These cells do not circulate in the blood of healthy individuals, but may be found in the bone-marrow and are the mother-cells of the polynuclear leucocytes. Two varieties of these cells are found.

The one, **Cornil's myelocyte**, is a large cell which has a circular or irregular-shaped nucleus usually placed on one side of the cell, the latter having a small amount of protoplasm-containing neutrophile granules. These granules stain only faintly. The other variety, **Ehrlich's myelocyte**, is somewhat smaller than the first variety and contains a round or oval nucleus, which is usually located centrally, but may be to one side. The nucleus stains more deeply than that of the former variety, and the neutrophile granules are usually more distinct.

In myeloid leucocythemia both varieties of myelocytes are present in the blood and predominate over all other forms of leucocytes. Ehrlich's myelocytes may be found in the blood in certain of the infectious diseases, especially in diphtheria, and sometimes in anemia.

Mast Cells.—These cells average only about 0.1 per cent. of all leucocytes and are often altogether absent in the healthy individual. They resemble the poly-

nuclear leucocytes as to size. The nucleus takes up a large part of the cell and is irregular in shape. The protoplasm contains only a few granules, which stain blue with Jenner's stain.

These cells are very much increased, as much as 10 per cent., in myeloid leucocythemia, and are diagnostic of this disease when found in that number.

LEUCOCYTOSIS.—By this term is meant an increase in the number of white corpuscles. It is present under certain physiological conditions, as during pregnancy, after cold baths, and after a hearty meal. As a rule, the presence of over 10,000 leucocytes per c.mm. should be considered pathological, the normal variation being between 5000 and 9000 cells.

In leucocythemia there is an extremely high leucocytosis, in some cases the leucocyte count being as high as 1,000,000. A high leucocyte count is also found in suppuration, diphtheria, hemorrhage, and meningitis. A moderate leucocytosis occurs in inflammatory conditions where pus is not present, tonsillitis, rheumatism, secondary syphilis, malignant tumors, and in typhoid fever when perforation has occurred.

LEUCOPENIA means a diminution in the number of leucocytes, and the relative proportion of white cells in this condition is usually changed. Leucopenia occurs in intoxications, malaria, typhoid fever, influenza, and pernicious anemia.

VARIATIONS OF VOLUME.—These may occur both in the mass proper and in the fluid portion of the blood:—

Oligemia means a reduction in the total volume of blood, as regards both plasma and cells; **plethora**, an increase in the total volume of the blood, the opposite of oligemia; **hydremia**, an increase in the fluid portion of the blood, and **anhydremia**, a diminution in the liquid constituents of the blood.

ERYTHROCYTES IN A STAINED SPECIMEN.—Normal red cells stain pink and do not need to be described. They are normally non-nucleated, but under some pathological conditions they may contain nuclei, when they are called **normoblasts**, **microblasts**, or **macroblasts** or **megaloblasts**, according to their size. Non-nucleated erythrocytes which are

normal in size are called **normocytes**; when larger than normal, **macrocytes** or **megalocytes**, and, when smaller than normal, **microcytes**.

Microcytes are decidedly small, non-nucleated cells which may be found in any severe anemia.

The **poikilocyte** is another form of non-nucleated red cell. This is an irregularly shaped red cell which may be of any size. This variety of red corpuscle is most commonly found in cases of pernicious anemia.

In any severe anemia, but especially in pernicious anemia, red cells are sometimes found which take the basic as well as the acid stain. These cells, therefore, are found to be stained with the different colors. **Polychromatophilic degeneration** or **polychromasia** is the term applied when this condition is present.

Another condition of the red corpuscles found in some of the severe anemias, but particularly von Jaksch's anemia of infants, is **granular degeneration**. Here the red cells contain many granules which are stained deeply by the basic stains.

Normoblasts are nucleated red corpuscles of normal size. They are normally present in the blood at and for a short time after birth, but later in life are found only in the bone-marrow, except under pathological conditions. The nucleus is found in the central part of the cell and is very large. It stains very deeply and there is only a narrow band of protoplasm surrounding it.

These cells are found in the blood in cases of anemia and are rather a good sign, showing that the bone-marrow is so active that some of the cells are extruded and enter the blood.

The **megaloblasts** are nucleated red cells which are very much larger than normal. The nucleus is small in proportion to the size of the cell and does not stain so deeply as that of the normoblast. When present in any number in the blood of adults these cells are almost diagnostic of pernicious anemia. They may also be found in the anemias of infancy.

BLOOD-PICTURE IN DIFFERENT DISEASES.—**Pernicious Anemia.**—The first striking characteristic of the blood noted in this disease is the high color-

index (usually over 1). It increases in proportion to the diminution in the number of red corpuscles. There is a leucopenia present, the leucocytes rarely being above 6000. The differential blood-count shows a relative lymphocytosis usually, the lymphocytes rarely being below 40 per cent. Megalocytes, megaloblasts, and normoblasts are usually present, and late in the disease poikilocytosis, polychromatophilic and granular degeneration may also be found.

Chlorosis.—In this condition the color-index is low (average is 0.5; may be lower); there is a reduction in the number of red corpuscles and a great reduction in the percentage of hemoglobin, causing the corpuscles to be very pale. The white corpuscles are usually normal in number, but there may be a leucopenia.

Secondary Anemia.—Here again the color-index is diminished, but not to such a great extent as in the previous disease. It rarely falls below 0.7. Both the number of red corpuscles and the percentage of hemoglobin are reduced, but there is usually a slight leucocytosis, the polynuclear leucocytes, especially, being increased. All those conditions which cause anemia and have a known cause are included under this heading.

Myelogenous Leucocythemia ("splenomedullary").—In this condition there is a very high leucocytosis, the white corpuscles in average cases reaching 400,000. All varieties of leucocytes are increased, but especially the polynuclear and eosinophile varieties. Both Cornil's and Ehrlich's myelocytes, large cells with basophilic granulations, and eosinophilic myelocytes are also present. There are many normoblasts present and usually anemia of a secondary type.

Lymphatic Leucocythemia.—Here again there is an enormous leucocytosis (100,000 to 1,000,000) especially affecting the lymphocytes, which may reach 99 per cent. There is also an anemia of the secondary type present.

Hodgkin's Disease.—This disease is very difficult to diagnose from the blood-picture alone, as in a true case of the disease there is no change in the blood-picture until late, when there is a slight leucocytosis with anemia of a secondary

type. In some cases the blood-picture may simulate that of lymphatic leucocythemia.

Splenic Anemia.—There is an anemia in this condition with a leucopenia usually. The color-index rarely falls below 0.7. Normoblasts, poikilocytosis, and polychromasia may be found. There is usually a marked increase of polymorphonuclears and a relative increase of all other forms of leucocytes, especially lymphocytes.

Infantile Anemia, Pseudoleukemia, or von Jaksch's Anemia.—Here a high leucocytosis and an extreme anemia are present. The color-index is usually low. All kinds of abnormal red cells may be found, normoblasts usually being quite numerous.

Secondary anemia in infants, such as occurs in rickets, scurvy, tubercle, and syphilis, shows a low color-index and, usually, a leucocytosis with a lymphocytosis. Normoblasts and, sometimes, megaloblasts may be found.

Septicemia.—The hemoglobin and red corpuscles are particularly involved in this condition. There is a reduction in both. The severer the case, the more rapidly the hemoglobin falls.

A diagnosis of septic infection after parturition can be made if a blood-count, made within a few days, shows a red blood-count below 4,000,000, providing there has not been any abnormal post-partum bleeding. A slight leucocytosis affecting the polynuclear cells may also be present.

Suppuration shows a high leucocyte count, varying between 15,000 and 25,000, the polynuclear cells usually being the ones increased. A valuable confirmatory test is the glycogen reaction, which is usually present (Emery).

Typhoid Fever.—There is a slight increase in the erythrocytes early in this disease, but, later, these cells are decreased in number. There is usually a normal or diminished leucocyte count and often a moderate lymphocytosis.

Should hemorrhage occur, there may be a fall in the number of red cells and a slight leucocytosis; but there is a rapid increase in the number of leucocytes (15,000 or more) if perforation occurs.

Pneumonia.—There is a moderate anemia of the secondary type in this disease and a marked leucocytosis proportionate to the extent of the lesion, the polynuclear cells being especially involved (may reach 95 per cent.). In some few cases of pneumonia there may not be a leucocytosis.

At the crisis the leucocytes usually fall to normal, but should the leucocyte count remain high after the crisis it is indicative of empyema.

Malaria.—In this condition there is an increase of the large lymphocytes, although the leucocyte count remains normal. Anemia is usually present. The blood should, of course, be examined for the specific micro-organism.

In **scarlet fever** and **whooping-cough** there is a leucocytosis, higher (20,000 to 60,000) in the latter than in the former (10,000 to 40,000) disease. The polynuclear cells are increased (80 to 90 per cent.) in the former disease, while there is a lymphocytosis in the latter.

In **influenza** and **measles** there is no leucocytosis if complications do not occur, while **rheumatism** shows a leucocytosis which if over 20,000 denotes the presence of some complication (endocarditis, pericarditis, pneumonia, etc.).

Tuberculosis shows a secondary anemia with a normal leucocyte count usually, although there may be a marked increase in the lymphocytes.

Syphilis.—This disease shows an anemia of the secondary type. There is a moderate increase in the number of white corpuscles (12,000 to 16,000) due to a lymphocytosis.

Purpura Hemorrhagica.—Here again there is an anemia with the color-index either normal or low. There is usually a leucocytosis due to an increase in the polynuclear cells, although there may be a leucopenia present with an increase in the lymphocytes.

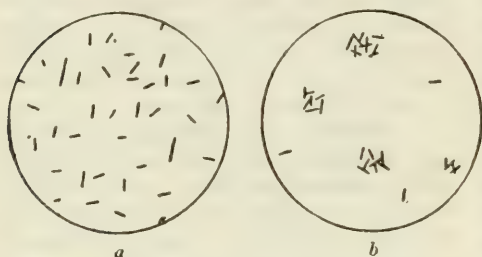
Carcinoma of the Stomach.—In this condition the blood-picture may show an anemia of the secondary type, a low color-index (average 0.63), and a slight leucocytosis (12,000 to 18,000) due mainly to an increase of the polynuclear variety (80 to 90 per cent.), or the color-index may be high and megaloblasts and megalocytes may be present.

Malignant tumors usually show a moderate polynuclear leucocytosis with slight anemia.

In **ulcer of the stomach**, **alcoholic cirrhosis of the liver**, and **hydatid cyst** a secondary anemia is usually present, but without a leucocytosis. In **Hanot's cirrhosis** and **abscess of the liver** leucocytosis is present. In hydatid cyst the differential count usually shows an increase in the eosinophiles.

Pleurisy with empyema, **bronchitis**, and **bronchopneumonia** show a moderate or high leucocyte count (18,000 or more).

Asthma shows a moderate leucocytosis and an eosinophilia, the latter being excessive (average 10 per cent.) during the attacks and moderate between them. The mast cells are said to be increased.



Stages in Widal reaction. *a*, negative reaction; *b*, positive reaction. (Robin.)

Valvular Lesions.—A differential count shows an increase in the red corpuscles (may reach 8,000,000) in mitral disease, and an anemia in the case of aortic disease, the leucocytes being normal in both conditions.

Non-suppurative inflammations of the uterus show a moderate leucocytosis, while **suppurative cases** shows a marked increase in the leucocytes; 18,000 usually indicate the presence of pus.

Leucocytosis may or may not be present in cases of **pyosalpinx** depending upon the cause.

Certain skin diseases, as **erythema multiforme**, **dermatitis herpetiformis**, and **pemphigus**, show an eosinophilia, sometimes as high as 10 per cent. A moderate or high leucocytosis may also be present.

OPSONINS AND OPSONIC INDEX.

—Sir A. Wright has demonstrated the presence in the blood of substances which

he calls opsonins, and which have the power of acting on pathogenic bacteria and so altering them that they can be taken up and digested by the leucocytes. These substances appear to be the chief agents in the production of some forms of immunity.

The method given by Wright is a general one, available for any organism, the only points of difference lying in the preparation of the emulsion of bacteria, which differs slightly with the various organisms. The process is not an easy one, and considerable patience and some practice are required for its mastery. It is fully described under **BACTERIAL VACCINES**, Vol. II.

SERUM REACTIONS.—The **Widal Test**.—This blood test, used for the diagnosis of typhoid fever, depends upon the action of bactericidal substances developed in the blood of typhoid patients on cultures of *Bacillus typhosus*. If we add 1 part of typhoid blood-serum to 10 parts of a twenty-four-hour broth culture of *Bacillus typhosus*, the bacteria become motionless and separate from the fluid in clumps. This reaction may be seen in a hanging-drop preparation of the culture to which a drop of dissolved blood is added from a platinum loop. The motility of the bacilli is rapidly lost and they become clumped in characteristic masses.

When this test is carefully made, by the addition of 1 part serum to 10 parts culture, a prompt reaction means that the diagnosis of typhoid fever is extremely probable. A prompt reaction from 1 part serum to 20 parts culture almost certainly indicates typhoid fever. A negative reaction is of little value as against typhoid fever. Partial reactions are unreliable.

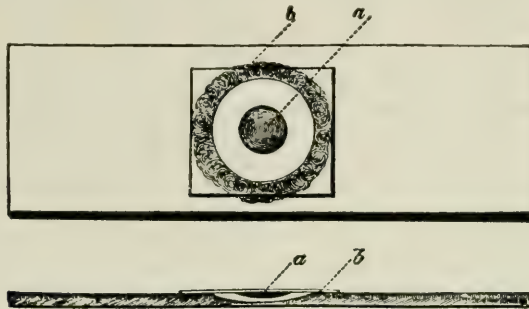
Technique.—The test is most often made from specimens of dried blood, a few drops of the latter being allowed to fall on glazed paper and dry. Exact dilution in this case is impossible, but if we dissolve the clot in an equal quantity of distilled water and mix 1 part of the solution with 10 parts of the culture, by means of a capillary tube, practically accurate results may be arrived at. For mixing in this case, we may use the mix-

ing pipette of the hemocytometer, as it is graduated in 10 divisions, expelling the mixed fluids carefully on a cover-glass for a hanging-drop preparation. (Incidentally, we may explain that a hanging-drop preparation is made as follows: A drop of the mixed fluids is placed on a clean, dry cover-glass and a hollow-ground slide with a ring of oil painted around the well is laid on the cover-glass and pressed down so that the oil around the well adheres to the cover-glass; if the slide be now inverted, the hanging-drop preparation is made, the bacilli being contained in the droplet of fluid which hangs from the lower surface of the cover-glass. The preparation will not dry if the seal made by the oil is perfect.)

sists in the blood for months, or even years, but after three or four months it is usually feeble.

The Wassermann Reaction.—This is a reliable blood-test for syphilis that is applicable very early in the disease and under conditions in which material containing the specific organism (*Spirochete pallidum*) is unobtainable. The theory of the reaction is rather complicated, and for its comprehension an understanding of hemolysis and immunity is essential.

Hemolysis.—This term means the decolorization and dissolution of blood-cells, and particularly of the red corpuscles. If the latter are mixed with normal saline, or other inert, solution they, the red cells, will gradually fall to the bottom of



Hanging-drop preparation. (Crookshank.)

When the reaction is strong the lost motility and clumping are complete by the time the specimen is ready for examination. A distinct reaction may require the lapse of from five to fifteen minutes. In feeble reactions clumping may not be complete until after a half-hour, and the motility of some bacilli may remain unaffected; in these the reaction is unreliable as an evidence of typhoid. The culture used in these tests must be a twenty-four-hour culture of medium virulence, actively motile, and grown in an incubator.

Occurrence of the Reaction.—Experience has shown that the Widal reaction is present in typhoid fever: In 70 per cent. of cases from the fourth to the seventh day; in 80 per cent. of the cases from the eighth to the fourteenth day; in 90 per cent. during the third and fourth weeks. In from 5 to 10 per cent. of the cases it is absent throughout. The reaction per-

the vessel, forming a red deposit, leaving above a clear, colorless fluid. If, however, certain other substances are present the cells will become decolorized, by losing their hemoglobin, which will impart a red color to the fluid. There will be practically no deposit, as the stroma of the cells is quite invisible. Of the many substances (hemolysins) that will cause this hemolysis we will here only consider those of the blood-serum. As a rule, the normal serum of one animal will not hemolyze the red cells of another species, but it can acquire hemolytic properties by injecting the animal with red cells from an animal of the second species. The serum of a normal rabbit will not hemolyze human red corpuscles, but if the rabbit is injected with 2 or 3 doses of human red corpuscles, a few days apart, the serum of the rabbit will be found to hemolyze the human red cells when mixed with them and incubated at body

heat. In the same way if a normal rabbit be injected with sheep corpuscles the rabbit's serum will hemolyze the sheep's corpuscles, but it will have no effect on the human corpuscles. This hemolytic power, therefore, can only be gained by injecting the animal, or immunizing it, with red corpuscles from the species of animal whose red blood-cells are to be hemolyzed.

This hemolytic power is due to two substances, one of which is always present in normal serum, the other being produced by the injection. The former is called *complement*. Though it is present in all serum, it varies in amount and is easily destroyed by heat (130° F. for half an hour, or 140° F. for ten minutes), and it vanishes in a few days at room temperature, in its behavior to heat resembling the enzymes. The second is called *amboceptor*. This, as may be inferred, is rarely present in normal serum, but is produced by the injection of alien cells. It is not easily destroyed. Heat that would efface every trace of complement has no effect on amboceptor, and at room temperature it will remain in serum for months. Hemolysis depends on the presence of *both* substances. No hemolysis will occur if either is absent. The union of the three elements (corpuscle, amboceptor, and complement) form a *hemolytic system*, which at body temperature goes into solution. If we wish to ascertain the presence of complement in any fluid (serum, normal saline, etc.), we have merely to add corpuscles that have been saturated with amboceptor; if hemolysis occurs it demonstrates the presence of complement in the fluid examined. This point has an important bearing on the interpretation of the Wassermann reaction.

Blood-corpuscle Emulsion.—To prepare this make a saline solution containing 0.9 per cent. salt and about 2 or 3 per cent. sodium citrate. Drop a small amount (10 to 20 drops) of blood from a finger puncture into 10 c.c. of the saline solution and centrifuge until the corpuscles are deposited and the fluid clear. Pour off the fluid and replace it with ordinary normal saline; mix thoroughly and centrifuge again; repeat the process once

more. The corpuscles will now be washed free of serum. With a pipette take 9 units of saline solution and 1 unit of the washed corpuscles and mix them thoroughly. This will make a 10 per cent. emulsion of corpuscles ready for use.

Absorption of Complement.—It has been found, by experiment, that if a portion of serum from a syphilitic containing complement is mixed with certain emulsions of fatty substances and then incubated the complement will be absorbed or disappear. This disappearance does not occur if serum from a non-syphilitic is used. In other words, the serum of the syphilitic by the above treatment loses one element of the hemolytic system, and we should naturally expect no hemolysis when amboceptor is added, and the mixture incubated, and this is what actually occurs, the absence of hemolysis being recorded as a positive reaction. To be certain that complement was present in the syphilitic serum before the addition of the fatty emulsion, the serum should receive a preliminary test with amboceptor; the occurrence of hemolysis would denote its presence. This completes the theory and explanation of the Wassermann reaction.

Antigen.—The emulsion of fatty substances is called *antigen* and may be prepared in several ways. Minced liver (sheep or human) may be used. To each gram add 3 c.c. of absolute alcohol. Mix them well by thorough shaking, and allow the mixture to stand for twenty-four hours, occasionally shaking it. Then heat in a water-bath at 60° C. (140° F.) for an hour and again shake thoroughly. Allow the mixture to settle. The clear supernatant fluid when required for use is prepared as follows: 9 volumes of normal saline solution, measured by means of a pipette, are placed in a small test-tube ($\frac{1}{8}$ inch diameter and 2 inches long). Next float 1 volume of the alcoholic antigen on the surface of the saline solution. A turbidity appears at the zone of contact, due to the precipitation of liquid substances from the antigen. Allow it to stand for four or five minutes, then gently shake the tube to cause partial admixture of the fluids. Repeat the gentle shaking after another similar interval, and finally

complete the mixture by stirring the contents of the tube. Before using, the alcoholic solution of antigen must be carefully tested and standardized.

An improved antigen, suggested by Emery, is prepared by making a 10 per cent. alcoholic extract of heart-muscle (freed from fat and fibrous tissue), and adding to it a 1 per cent. alcoholic solution of cholesterin in the proportion of 5 to 4. This is to be mixed *rapidly* with saline solution in proportions to be determined by experiment.

Illustration.—Take 1 volume of fresh serum from a normal person (not affected with syphilis) and 4 volumes of the diluted antigen (described above), and incubate for ten minutes. Then add 1 volume of immunized rabbit serum, heated, and 1 unit of human red-corpuscle emulsion. The corpuscles will be dissolved. As hemolysis has occurred, this is a negative Wassermann reaction. The complement does not disappear in the presence of the antigen.

Again, take 1 volume of fresh serum from a well-marked syphilitic, untreated, and preferably in the secondary stage, and 4 volumes of diluted antigen. Mix, incubate, and add immunized serum or an emulsion of red corpuscles. The corpuscles are not dissolved. As there is no hemolysis, this is a positive Wassermann reaction. The complement of the syphilitic serum was absorbed when incubated with the antigen, and the hemolytic system broken. This is the simplest exposition of the Wassermann reaction. The technique of the original Wassermann method is very complicated and is rather beyond the facilities of the general practitioner. Emery has elaborated a modification of the Wassermann reaction which any careful physician can use, and which gives as good results as the original.

Emery's Modification of the Wassermann Reaction ("Clinical Bacteriology and Hematology," 4th ed., 1912).—*Collection of Blood.*—Ten to 20 drops of the blood should be collected in a Wright curved pipette. Incubate the specimen for half an hour to insure a well-retracted clot and a good crop of serum. Centrifuge specimen to throw down clot and insure clear serum.

Preparation of Antigen.—Prepare and dilute antigen as already described. Test the antigen before use, as all samples are not equally potent: Obtain a half-dozen specimens of normal serum, not more than twenty-four hours old. With each specimen make the following two preparations in small test-tubes—(a) 1 part serum + 4 parts normal saline solution; (b) 1 part serum + 4 parts of the antigen (diluted 1 in 10) to be tested. Incubate for five minutes in water-bath at 37° C., or for fifteen minutes in an ordinary incubator. Now add 1 part of a mixture of 1 part of washed human corpuscles + 4 parts of serum from a rabbit immunized



Wright's blood capsule, about two-thirds size.
(Emery.)

to human corpuscles. Stir once or twice with the pipette, sucking the fluid up and expelling it again, and allowing the mixture to stand. The red corpuscles in (a) should be almost or quite dissolved; the proportions are arranged so that there is sufficient complement to effect this, provided there is sufficient amboceptor fully to sensitize the corpuscles. In the (b) tube there should not be quite so much hemolysis—at any rate, not in all the tubes, if several specimens of normal blood are examined. In other words, *the antigen should be of sufficient strength to cause slight inhibition of hemolysis with a specimen of normal blood.*

The antigen should now be tested with a specimen of syphilitic blood. The (a) tube should show complete, or almost complete, hemolysis, as before, but there should be none whatever in the (b) tube;

the corpuscles should sink down, leaving a clear, colorless, supernatant fluid. If these two criteria are present the antigen is fit to use. If not, discard it and prepare fresh. The antigen should also be examined from time to time, as it occasionally undergoes rapid changes in strength.

Preparation of the Emulsion of Corpuscles.—This has been described. They should be washed at least three times, using normal saline containing citrate of soda (to prevent coagulation) the first time, plain sterile normal saline afterward.

The Amboceptor.—This should be tested with normal serum in the same way the antigen was tested. A series of preparations of normal serum, the (a) tube containing 1 part normal serum + 4 parts of normal saline, the (b) tube containing 1 part of normal serum + 4 parts of good antigen (diluted 1 in 10), should be incubated, and then 1 unit of a mixture of 1 part of red corpuscles and 4 parts of the amboceptor serum to be tested should be added and stirred occasionally. There should be complete hemolysis in the (a) tube, nearly complete in the (b) tube. Too weak a serum will give an apparent positive result, with many normal sera; some complement is absorbed by the antigen, and not enough is left to hemolyze the partially sensitized corpuscles. Such amboceptor is useless and misleading.

Apparatus.—Any good incubator may be used, ten to fifteen minutes being allowed for each incubation. The tubes may be stuck side by side on a slip of wood or box-lid covered with plasticene.

The test-tubes should be 2 inches long and have an internal diameter of about $\frac{1}{8}$ inch.

One pipette, such as is used for opsonic work, the Widal reaction, etc., is necessary. It should not be too wide (to avoid waste of material), and a unit mark should be made $\frac{1}{2}$ inch from the tip. Then take 4 of these units of water, expel them into a dish, and suck them into the pipette so as to form a continuous column. Make a mark to indicate the upper level of the column. The pipette will now measure 1 or 4 units of any fluid quickly and accurately.

Technique.—Take 1 unit of the serum to be tested and 4 units of normal saline solution and mix them in a test-tube. This is the control to see whether there is sufficient complement for the test, as is practically always the case with fresh serum.

Take 1 unit of the serum and 4 units of the antigen (diluted 1 in 10), and mix. This is the actual test.

Incubate fifteen minutes or more in the ordinary incubator. While this incubation is under way, prepare the mixture of sensitized corpuscles by taking 4 parts of the amboceptor serum and 1 part of the deposit of red corpuscles and mix.

Now add 1 volume of this latter mixture to each tube. After a few minutes, mix by sucking the mixture into the pipette and expelling it again once or twice. If the corpuscles in any tube are not practically dissolved, repeat this process after a few minutes more. Allow to settle, and read off the result.

In a *negative test* there will be complete, or nearly complete, hemolysis in both tubes.

In a *positive test* there will be complete, or nearly complete, hemolysis in the first tube, and no hemolysis in the second.

As this process is very simple, there is very little chance of technical error; the only fallacies likely to arise are from the use of unsuitable materials, especially the antigen, a source of error common to all methods. With this method a rapid quantitative estimation may be made, by determining the highest dilution of antigen which will just give a positive reaction. Suppose there is no hemolysis with the 1 in 10 dilution. Use a second antigen diluted 1 in 30, and repeat the test. If there is still no hemolysis, try at 1 in 50, and, if necessary, higher. Emery regards a reaction at 1 in 10 as definite but weak, one at 1 in 30 as moderate, and one at 1 in 50, or over, as strong. He has observed a serum which reacted positively with antigen diluted over three hundred times. This is the simplest method of making a quantitative test. A series of quantitative tests enables one to estimate the effect of treatment.

Interpretation of Results.—In the primary stage a positive reaction may be

looked for as soon as there is a definite infiltration of the chancre; it may, however, be delayed. In doubtful cases look for spirochetes. If the Wassermann is positive it is conclusive; if negative it may be syphilis, especially in the very early stages.

In the secondary stage a positive reaction may be expected in nearly all cases. Given a doubtful rash and a negative reaction, syphilis may almost certainly be excluded.

In the tertiary stage a positive reaction is the rule in the beginning, but it becomes weak, if the disease becomes latent; in some cases it entirely disappears. A gumma or syphilitic ulcer may be present in the late stage, twenty years after infection, with negative reaction.

The reaction may or may not be present in parasyphilitic cases. It is usually present in general paralysis, more frequently absent in tabes. A positive reaction here is an indication for active antisyphilitic treatment. In the cerebro-spinal fluid the reaction is generally present, while in tabes it is frequently present.

In congenital cases the reaction is strongly positive even when signs of the disease are absent. The mothers of these children usually give a positive reaction.

Mercury removes the reaction before the disease is cured; this is also the case with "606" (salvarsan).

A persistent negative reaction indicates cure, but reinoculation is possible.

A patient with positive reaction may have some other disease in addition to syphilis. Save in the case of scarlet fever, no other disease, met with here, except syphilis gives a positive reaction.

The Noguchi Butyric Acid Reaction.—Noguchi discovered that in cases of secondary syphilis, untreated or under mild medication, an increased globulin content in the serum could be demonstrated by the precipitation produced by the addition of butyric acid.

Technique.—Mix the serum with a semi-saturated solution of ammonium sulphate; separate the precipitate by means of the centrifuge, and pour off the supernatant fluid. Redissolve the precipitate in ten times its volume of normal salt solution, and add slowly a 10 per cent. solution of

butyric acid in normal salt solution. A normal serum thus treated throws down a slightly opalescent precipitate, but the serum of secondary syphilis shows its increased globulin content, by producing a distinct flocculent precipitate which forms within a couple of hours. This reaction may also be applied to the spinal fluid, though the technique is somewhat different.

The Abderhalden Test.—This biological test is usually thought to apply to *pregnancy* only, but it is now known to be of diagnostic value in many disorders to which reference will be made below. It is based on the following principle enunciated by Abderhalden: Where a certain group of cells, or an organ, becomes diseased, material foreign to the blood-plasma may be liberated which will provoke the formation of ferments. Detection of the latter, in turn, will permit of ascertaining what particular organ is involved. Thus, if a certain serum breaks up the thyroid gland only, the deduction can be made that in the patient from whom the serum was obtained the thyroid is in a pathological state and is secreting substances foreign in composition to the blood-plasma. Analogous ferment production takes place in disease of various other organs and tissues, as well as upon introduction of blood-foreign materials from the exterior. Abderhalden's discovery (1912) of proteolytic ferments in the serum of pregnant women has thus led many other observers to apply the same diagnostic principle in a large series of abnormal states.

In pregnancy the diagnostic value of Abderhalden's reaction is well established. It is the equivalent here of Wassermann's reaction in syphilis, inasmuch as the result of the test is positive in 80 to 90 per cent. of the cases. A positive Abderhalden reaction, then, may be considered one of the symptoms of pregnancy and may be of practical diagnostic value in the differentiation from pregnancy of uterine fibromyoma; in the diagnosis of pregnancy in obese cases; as an early test for it where some general disease, such as tuberculosis, may necessitate evacuation of the uterus, and in the distinction of extrauterine pregnancy from tumors of the adnexa.

The presence of the Abderhalden "protective ferment" corresponding to a given abnormal condition can be detected in two ways: (1) by the method of dialysis, and (2) by the optic method.

The following description of the technique of these methods, with the necessary preliminary procedures, as well as the subsequent statements concerning the field of application of the test, are due to Dr. M. G. Wohl, of the Pathological Department of Temple University, who sets forth the dialytic method as carried out by himself with uniformly accurate results in a series of 22 cases of pregnancy, as well as in other special work:—

Technique of the Test.—One-half Gm. of prepared placental tissue—or any other tissue used for the test—is placed in a dialyzing thimble which has previously been tested for impermeability to albumin and regular permeability to seide peptone; 1.5 c.c. of the blood-serum under examination, absolutely free from hemoglobin, is put into the thimble and is dialyzed in 20 c.c. of distilled water. The contents of the thimble and external fluids are covered with sufficient toluol to prevent putrefaction and evaporation. The exterior of the thimble is washed with water, which is prevented from entering the thimble by pressing the top together. The thimble is now kept in the incubator for sixteen hours. Then 10 c.c. of the diffusate is removed to a dry test-tube and boiled with 0.2 c.c. of a 1 per cent. solution of ninhydrin. A rod to facilitate boiling is inserted in the tube. If, after standing half an hour, the solution remains colorless, the test is negative. Controls with the serum alone and with the tissue alone, respectively, are to be employed.

Preparation of Placental or Other Tissues.—Free the placenta from blood by thoroughly washing it with tap water. Cut the placenta into small pieces, grind these in a mortar, and remove the last drop of blood that may be present. Now boil the placental tissue for five minutes, adding to the water a drop or two of glacial acetic acid. Repeat this six times, using the glacial acetic acid only for the first boiling. Filter 4 c.c. of the water of the last boiling, add to it 1 c.c. of a 1 per cent.

aqueous solution of ninhydrin, and boil for one minute. If the tube remains colorless, preserve the tissue in a well-stoppered bottle to which enough toluol has been added to prevent putrefaction. The preparation of the placenta must be conducted uninterruptedly and under perfect aseptic conditions.

Test for Impermeability of Dialyzing Thimbles to Albumin.—Place the thimbles in water for half an hour. Add to each thimble 2.5 c.c. of a 5 per cent. solution of egg albumin. Wash off well the outside of the thimble and place it in a beaker into which 20 c.c. of distilled water have been introduced. Cover the contents of the thimble and the surrounding fluid with toluol. Place in the incubator at 37° C. for sixteen hours. Remove 10 c.c. of the diffusate and add 2.5 c.c. of a 33 per cent. solution of sodium hydroxide. Now pour slowly along the side of the tube 1 c.c. of a 1:500 solution of copper sulphate. If a violet ring forms between the upper blue layer and the lower colorless layer the thimble should not be used for the test.

Test for Permeability of Thimbles to Peptone.—If the thimbles prove impermeable to albumin, they are next well washed and placed in running water for twelve hours; 2.5 c.c. of a 1 per cent. solution of seide peptone is added to each thimble, the sides of the thimble being washed off. Toluol is added, and the thimbles are placed in beakers into which 20 c.c. of water has been introduced and then into the incubator. After sixteen hours 10 c.c. of the diffusate is removed and 0.2 c.c. of a 1 per cent. solution of ninhydrin added. The tube, in which a rod has been placed, is boiled for one minute. If a deep violet or blue color appears after the tubes have stood half an hour the thimbles are permeable to peptone.

The thimbles are next again washed and placed in running water for twelve hours. They are then ready for the test.

Optic Method.—The technique of this method is very simple, but accurate reading requires great skill and experience. Add to 1 c.c. of hemoglobin-free serum 1 c.c. of a 5 to 10 per cent. peptone solution of the organ used. Shake thoroughly,

place in the tube of the polariscope, and determine the number of degrees of rotation after the latter has reached 37. If no rotation takes place, no ferments are present.

The author has records of 21 pregnant and 4 puerperal cases in which the Abderhalden test invariably gave the violet-blue ninhydrin reaction, while the control remained colorless. These cases covered a period from twelve days after the missing of the menses to the fourteenth day *post partum*. He also has records of 18 non-pregnant cases, including several tubal enlargements, 4 uterine fibroids, and 2 males, in which the dialysates of both test and control remained colorless.

In 8 instances the serodiagnosis was employed as the only means of differential diagnosis, and in each its answers were correct. One was a girl twelve days overdue on whom criminal abortion had been attempted, but who denied the charge and refused pelvic examination. Two patients in whom tubal pregnancy had been considered proved non-pregnant, the one had a pyosalpinx and the other a chronic parametritis. A woman whose youngest child was 18 years of age, and who was four weeks overdue, proved to be pregnant.

A young woman with irregular menstruation who had often skipped two or three months, and was again eight weeks overdue, proved non-pregnant and the menses returned later. In another case, in which there were good reasons for interrupting a possible pregnancy and which gave a positive reaction when two weeks overdue, the author emptied the uterus and removed the ovum.

In all these cases the control was carried on with inactivated serum and placenta, and was extended to the examination of a case positively pregnant and to another case positively not pregnant. Henry Schwarz (Jour. Amer. Med. Assoc., Aug. 16, 1913).

Other Applications of the Abderhalden Reaction.—This reaction is proving of distinct aid in the study of the **toxemia of pregnancy**. Examining serums of 3 cases of pernicious vomiting and of 1 case of eclampsia, Wohl detected in all 4 cases a ferment directed against placenta and liver tissue. In 2 instances kidney substance was not broken up, while the urine yielded a heavy ring of albumin. These observations point to the liver as being a factor in the toxemia of pregnancy, while the kidney may remain unaltered. The albumin might be accounted for by filtration through the kidneys of the accumulation of placental albumin in the maternal blood.

Wohl thinks that eclamptic patients might be benefited by the administration of artificially prepared proteolytic ferments. In the literature there are reported toxemic cases which, after a venous transfusion from normal pregnant cases, showed great improvement.

Infectious diseases afford exceptional opportunities for the use of Abderhalden's reaction. Tuberculosis and glanders have given positive results so far in the hands of Abderhalden himself. In scarlet fever Schultz and Grote found a ferment against lymphoid tissue; this agrees with Bernhard's transmission of scarlet fever to monkeys by inoculating them with lymphoid tissue from cases of this disease.

Neurology is also profiting by Abderhalden's reaction. Fauser, Wegener, and others found in cases of dementia precox a ferment which digested brain cortex, testicle, and ovary, respectively, whether the serum of a male or a female was used. Myer and others have likewise obtained in such cases a ferment against the thyroid gland.

In a series of cases of mental diseases under the observation of Weisenburg and Wohl, the findings were as follows: In 6 cases of dementia, brain cortex, ovary, and testicle were broken up. In 14 cases of epilepsy it was noticed that, where the condition has progressed to the stage of dementia, brain and testicular tissue are split up. Thyroid gland was broken up in 2 instances. In one patient who had had an attack five minutes before the blood was obtained the serum showed a

strongly positive reaction (deep blue) with brain substance and testicular tissue.

[Thyroid gland, testicle, and ovary evidently stand in direct relationship to dementia precox, as Fauser had concluded from his research. Whether an epileptic attack is due to a ferment causing cleavage of brain tissue, as Biswanger believes, and testicular tissue, as Weisenburg and Wohl found, cannot now be definitely stated, but it is probable that where the reaction is positive during the intervals between seizures the case is progressive and the prognosis unfavorable. WOHL.]

The reaction may also be of assistance in differentiating a hysterical from an epileptic attack.

Epstein, Gambanoff, and others found the Abderhalden reaction positive in all the cases of cancer they studied. In 2 of Wohl's cases of cancer of the sigmoid and breast, respectively, a positive reaction was obtained, and the diagnosis was confirmed by the microscopic examination of the tissues removed. The test bids fair to prove of great importance in the early diagnosis of cancer, as well as in the control of the post-operative treatment of patients afflicted with this disease.

Bauer, Kolb, and others have found ferments in Basedow's disease against thyroid and thymus, and against ovarian and testicular tissues in the female and male, respectively. These findings would indicate that the thymus and genetic cells have some bearing upon the origin of exophthalmic goiter. Practically, the test may be utilized as an aid in the diagnosis of a hyperplastic thymus and thus post-operative deaths in Basedow's disease, attributable to an hyperplastic thymus, be avoided.

In dermatology the Abderhalden reaction is likewise finding a recognized place. Reines and Bauer found a ferment against the thyroid gland in cases of scleroderma.

An attempt to elucidate certain obscure conditions in ophthalmology by means of Abderhalden's reaction is being made by Hegger and Hippel, who have found a ferment operative against the uveal tissue in cases of acute inflammation of the uveal tract.

The Abderhalden reaction is of the greatest value, elucidating as it does obscure features of immunity, the cell proper and its proteins, colloid chemistry and ferment action. In its application to the diagnosis of pregnancy, disorders of the ductless glands, dementia precox and various infectious diseases, it fails to correspond with experimental data, but this only indicates the need of explanations. Wallis (*Quarterly Jour. of Med.*, Sept., 1916).

The recent applications of the Abderhalden reaction are reviewed under the headings of the various conditions in which it has been employed. H. and W.

HEMATOPORPHYRINURIA.

—**DEFINITION.**—Evacuation of urine containing hematoporphyrin, *i.e.*, a coloring matter resembling hematin, but containing no iron. By some it is believed to be simply hematin without its iron.

SYMPTOMS.—The urine is dark red or brown (resembling port wine). The ordinary reactions for hematin or hemoglobin do not give positive results. Examination by means of the spectroscope reveals characteristic absorption-bands. It is accompanied by marked exhaustion, constipation, tympanites, nausea, and intestinal pain. The case may appear relatively unimportant, then suddenly assume a lethal trend. In chronic cases nervous trophic disorders develop.

In the 14 acute cases of hematoporphyrinuria reported to date, the syndrome was characterized by intestinal disturbances, vomiting, constipation, and abdominal pain. Five of the patients died, 4 of whom had paralysis of the Landry type; the others recovered. Acute toxic hematoporphyrinuria is found in chronic intoxications with sulphonal, trional, and veronal, but is not present in the acute cases of poisoning with these drugs. There are 9 cases of chronic hematoporphyrinuria on record; these were characterized by sensitiveness of the skin to light, inducing hydroa estivale, and in 1 case there was also scleroderma. This chronic form is

the congenital hematoporphyria. The hematoporphyria and hydroa estivale began in early childhood; later (18 to 45 years) mutilations develop, especially on the nose, ears, cheeks, backs of the hands, and fingers. The urine looks like port or Burgundy wine. Günther (Jour. Amer. Med. Assoc., from Deut. Archiv f. klin. Med., Bd. cv, Nu. 1-2, 1912).

Case due to excessive use of trional and sulphonal in a man aged 39 suffering from neurasthenia and insomnia. The symptoms were profound exhaustion of body and mind, obstinate constipation, tympanites, nausea, occasional vomiting, and much abdominal pain, localized around the navel. The urine was scanty and presented the appearance of free blood, but failed to react to blood tests. These symptoms grew worse and the patient died from exhaustion about twenty-five days after the symptoms were noticed by the physician. The patient had been taking daily about 12 grains (0.77 Gm.) of sulphonal for four or five weeks with an occasional dose of 15 grains (1 Gm.) of trional. A. W. Rogers (Jour. Amer. Med. Assoc., May 18, 1912).

Case of porphyria in which the patient passed urine of a reddish-brown or port-wine color, and had nausea and vomiting, with loss of weight. A sister, 18 years old, had died with the same symptoms, and another sister was now similarly affected. The father had signs of Graves's disease. The patient reported had also enlargement of the thyroid gland, gastroduodenal dilatation, and suffered from tetanoid attacks. The urine, of port-wine color, contained hematoporphyrin, as shown by spectroscopic examination. Later acetone appeared, but no diacetic acid. Signs of general multiple neuritis developed, followed by death from bronchopneumonia. Seven cases similar to this were reported in literature. L. F. Barker (N. Y. Med. Jour., June 8, 1912).

ETIOLOGY.—Hematoporphyria is the consequence of prolonged use of sulphonal, trional, veronal, and saffron.

Case of hematoporphyria showing the enormous amount of hemoglobin that may be destroyed. In the writers' case about one-seventeenth of the hemoglobin was destroyed and wasted in the urine during twenty-four hours in the form of hematoporphyrin. Such a loss of blood-pigment sustained for a prolonged period of time will soon lead to severe degrees of anemia. This patient had been taking from 20 to 60 grains (1.3 to 4 Gm.) of sulphonal nightly for several years, but recovered when the drug was stopped. J. Tyson and A. C. Croftan (Phila. Med. Jour., May 17, 1902).

Case in which the patient took repeated doses of saffron to induce abortion. Several similar cases are recorded in the literature. The symptoms of saffron poisoning, besides the hematoporphyria, are colic, vomiting, purging, and convulsions, followed by delirium and coma. S. Wiener (N. Y. Med. Jour., Jan. 14, 1911).

It is also witnessed in many acute fevers, when hemorrhage occurs in the intestine from any cause.

TREATMENT.—This consists in removal of the cause and immediate efforts to reconstruct the blood. In severe cases **transfusion** is necessary. **Hypodermoclysis** with **adrenalin** 1:1000 solution, 20 minims (1.25 c.c.) injected into the rubber tube while the **saline solution** is being injected, may also be tried. **Blaud's pill**, 5 grains (0.3 Gm.) *t. i. d.*, with **adrenal gland** in the same dose, aid to rebuild the hemoglobin. All prescriptions for trional, veronal, or sulphonal should forbid its renewal by the druggist without specific orders from the attending physician.

Case of a woman aged 69 who became progressively weaker, passed urine and feces involuntarily, gradually sank into coma, and died ten days after the peculiar color of the urine was first noticed. The urine remained of the same character to the

end. The symptoms were characteristic—pigmentation of the urine, acute vomiting, with constipation, progressive weakness, obscure nervous symptoms, such as ataxia, mental confusion, and, finally, incontinence of urine and feces, and death in coma.

Cases are recorded which have occurred after only a few doses of sulphonal, but in most of the cases the drug has been taken regularly for several weeks. Large single doses never cause it. It is claimed that the danger can be avoided by periods of intermission in the use of the drugs, and that the symptoms are due to a gradual accumulation in the system. In the case reported only a small number of powders had been prescribed originally, with directions for them to be taken occasionally as emergency arose. The patient had had the prescription repeatedly filled on her own responsibility, and had been taking the powders every day without consulting a physician. H. B. Cushing (Montreal Med. Jour., Sept., 1910). L. and S.

HEMATOXYLON.—The common name of this drug is logwood. It is the heart-wood of the *Hematoxylon campechianum*, a small tree, with irregular, spinous branches, growing in Central America and the West Indies. It occurs in reddish-brown chips, has a faint, agreeable odor and a sweetish, astringent taste. The freshly cut surface is of a yellowish-red color; a greenish, metallic luster indicates that it has undergone fermentation and should be rejected.

Hematoxylon contains hematoxylin to the extent of 10 or 12 per cent.; also tannic acid, a volatile oil, resin, and calcium oxalate. Hematoxylin occurs in colorless crystals, which become dark red when exposed to light. It is soluble in both water and alcohol, and is used extensively for the staining of histological specimens.

Hematoxylon is incompatible with the mineral acids, opium, tartar emetic, lime-water, ammonia-water, and metallic salts.

PREPARATION AND DOSE.—*Extractum hamatoxyli*, U. S. P. (extract of

hematoxylon), made by macerating 1 part of the drug in 10 parts of water, boiling, straining, and evaporating to dryness. Dose, 15 grains (1 Gm.).

PHYSIOLOGICAL ACTION.—Hematoxylon is an astringent and is also credited with a slight antiseptic action. It tends to coagulate albumin. It imparts a red color to both the urine and the stools when given internally.

THERAPEUTICS.—Externally, the extract is said to be of value in **ulcers** and **gangrenous conditions**. On account of its astringent action it may be used locally for the relief of **leucorrhea** and is also sometimes used for **hemorrhoids**.

Internally, the extract is used in **diarrheal conditions**, being of particular value in tuberculous diarrheas. It may also be given in nervous diarrheas and diarrheas occurring in young children, its relatively pleasant taste facilitating administration. It may be given in combination with other astringent drugs. H.

HEMATURIA. —DEFINITION.—Evacuation of urine containing blood.

SYMPTOMS.—Urine containing but a little blood may not give any indication of its presence to the naked eye; but when the quantity is larger, it presents a characteristic smoky appearance; when more abundant the fluid has a more or less pink or red color, while the surface presents a tinge of green; in extreme cases it looks almost like pure blood. After a time a brownish or grayish, gum-mous, flocculent sediment is deposited. When the blood is abundant it often separates from the urine in distinct clots. Although the appearance of the urine is very characteristic, various other coloring matters may be contained in the urine and give rise to delusions. These are phenol, santonin, bile-pigment, the coloring matter of rhubarb, senna, etc.

Tests.—The presence of blood may be proved by different tests.

Heller's Test.—A few cubic centimeters of urine are rendered alkaline with caustic soda and heated in a test-tube to the boiling point; when blood is present the fluid becomes dark green; the phosphates are deposited as a flocculent sediment, carrying with them the coloring matter of the

blood by which they are colored red, or, rather, rusty brown. The alkaline solution of hemoglobin is dichroic; it shows a green tinge in thin layers and a red in thicker ones, while in the alkaline solution of *santonin* the coloring matter of *rhubarb*, *chrysarobin*, *rhamnus*, *senna*, etc., is not dichroic and takes on a violet hue after a time. In alkaline urines this method often produces no precipitate because the phosphates and carbonates have already separated out spontaneously. The necessary quantity of phosphates and carbonates may be supplied by adding to the specimen about an equal volume of a normal urine (*Sahli*).

The Guaiac Test (Almén-Schönbein).—One cubic centimeter of recently prepared tincture of guaiac is carefully mixed with an equal volume of ozonized oil of turpentine, *i.e.*, turpentine oil which has for some time been exposed to the influence of air. The mixture is cautiously poured upon the specimen of urine to be tested and will superpose itself, forming at the point of contact a gray or greenish layer; when blood is present a beautiful indigo-blue stratum will appear immediately above the gray ring; when shaken the mixture will take a light-blue color. Before making the test, we should see that the urine is acid or is made so by adding acetic acid. The guaiac test is very delicate, indicating blood in the proportion of 1:2000 or less and will sometimes give a positive result when the spectroscopic test fails.

The Benzidin Test (Schumm).—Ten c.c. of the suspected liquid is treated with 1 c.c. of glacial acetic acid. To this is added a third volume of ether. The supernatant ether is transferred to another test-tube containing a mixture of 0.5 c.c. of a glacial acetic acid solution of benzidin and 2 c.c. of hydrogen dioxide. If blood is present, the reagent turns green or blue, and then, in five minutes, a dirty purple.

Florence Test (for spermatic fluid).—To the suspected substance add a strong aqueous solution of iodine and potassium iodide. If spermatic fluid is present, brown plates or needles will be formed.

The Hemin Test (Teichmann).—Some of the sediment of the urine or of the red phosphates deposited after addition of

caustic soda is collected and dried. A small amount is placed on a glass slide and completely dried by slowly warming. When it is fixed on the surface of the glass, some common salt is rubbed on it, a fine hair is placed across the preparation, a few drops of glacial acetic acid are added, and the whole is covered with a cover-glass. The glass slide is heated to the steaming—not the boiling—point for one minute. A little acetic acid is added from time to time to make up for evaporation. If the fluid turns brown, it is warmed gently and then allowed to evaporate. When blood is present the characteristic small, reddish-brown crystals of hemin will appear, which are easily detected by the aid of the microscope.

Spectral Analysis.—Examination of a stratum of urine containing oxyhemoglobin 1 or 2 c.c. thick by transmitted bright daylight, sunlight, or lamplight through the spectroscope reveals two distinct absorption-bands between the lines *D* and *E* of Fraunhofer; recently passed urine never contains oxyhemoglobin, but methemoglobin (a modification of hemoglobin containing more oxygen than hemoglobin, but less than oxyhemoglobin). By decomposition of the urine or by addition of a solution of ammonia the methemoglobin is reduced to hemoglobin, which again forms oxyhemoglobin when shaken with air. The methemoglobin gives rise to the same two absorption-bands as the oxyhemoglobin, but, besides, to a characteristic band in red, between *C* and *D*. For clinical purposes a small hand spectroscope may be used. If the urine be dark or cloudy it must first be diluted with water. When the urine contains a very small amount of blood-pigment, an acetic acid solution of the hematin-containing precipitate obtained in Heller's test can be used for spectroscopic examination. The hematin bands will be seen. This method may also be used when the urine is so deeply colored from the presence of bile-pigments or urobilin that the hemoglobin or methemoglobin bands cannot be seen (*Sahli*).

Microscopic Examination.—This is the most reliable test for hematuria. The urine is centrifuged and the sediment examined; even when the amount of blood

is too small to alter the color of the urine the corpuscles of blood are easily detected by this method. Ordinarily the corpuscles are normal in appearance, but they do not accumulate in rolls; when the urine is dilute or alkaline, they are large, spherical, and almost colorless, commonly very transparent, whereas in concentrated urine their contour is irregular and indented; in some cases the corpuscles are broken up (fragmented); in others casts of renal tubuli formed by blood-corpuscles may be seen. The urine, naturally, is albuminous.

The admixture of blood to the urine may take place in the kidneys, the ureters, the bladder, or the urethra; in order to ascertain the origin of the blood, it is necessary to subdivide the urine when voided into several parts. The first portion voided may contain blood of urethral origin, and the urine last voided show none whatever.

When the portion last obtained contains much more blood than the first, the bladder probably is the seat of the bleeding. The endoscope will then generally allow the direct inspection of the bleeding-point on the mucous membrane of the bladder.

When the bleeding is caused by lesions of the ureters or of the calyces, cylindrical coagula or casts of the calyces may be found in the urine.

When the bleeding has taken place in the kidneys the blood is very intimately mixed with the urine; the corpuscles are often broken up or massed together, and casts of the renal tubes are commonly found.

ETIOLOGY.—Hematuria is more frequently observed in men than in women or children. The blood in hematuria may come from the kidneys, their pelves, the ureters, the bladder, or from the urethra.

Bleeding from the anterior urethra may be caused by acute or chronic gonorrhea, by traumatism (calculi, introduction of catheter), by polypoid excrescences, stricture, warty growths, tuberculous ulcers, or malignant tumors. In the posterior urethra the bleeding may come from enlarged or inflamed verumontanum, posterior urethritis, or inflammation of the prostate or seminal vesicles. The inflammation of the prostate may be gonorrheal, tuberculous, mixed infectious, or syph-

ilitic (gumma). The seminal vesiculitis may be cancerous, or due to mechanical violence or to stone.

Hematuria has been observed as a result of venereal excess or as an accompaniment of the first coitus after a long period of abstinence.

The causes of bleeding from the bladder are traumatism (calculi); diseases of the bladder, acute or chronic; varicosities of the veins (vesical hemorrhoids); ulcerations of the mucous membrane, diphtheritic or tuberculous; tumors, especially cancer of a villous or fungous nature; parasites, such as *Distoma hamatobium*, or *Bilharzia*, and *Filaria sanguinis*; it may also occur in hemorrhagic diathesis, in hemophilia, and also in infectious fevers, variola, etc.

Bleeding from the pelves or the ureters is generally caused by calculi or by tuberculous disease; also by acute infectious diseases of hemorrhagic character; by parasites (distoma and filaria).

Bleeding from the kidneys is frequently due to irritating poisons, such as cantharides, turpentine, hexamethylenamine, etc.; very large doses of quinine, and of salicylic acid are said to have produced renal hematuria.

Three instances in which hematuria developed very soon after the first dose of hexamethylenamine was given, and in none of which had more than 30 grains (2 Gm.) been administered. In the first two instances the drug was stopped at once, with the result that the hematuria also ceased. In the third patient the blood was ascribed to the fact that circumcision had been lately performed and, the drug being continued, decided symptoms of strangury and bladder irritation appeared, with a large amount of blood in the urine; but these symptoms were relieved as soon as the hexamethylenamine was stopped. Beardsley (Penna. Med. Jour., vol. ix, p. 691, 1907).

Different diseases of the renal blood-vessels may cause bleeding; for instance, embolism of the renal artery, thrombosis of the veins, aneurism, traumatism, and chronic interstitial nephritis.

Case with a history of renal hematuria of seventeen days' duration. Ureteral catheterization showed that the blood came from the left kidney. Both kidneys were normal in function. Left nephrotomy was done, and evidence of hemorrhage in the kidney substance was seen. The kidney was removed and showed a sub-acute hemorrhagic glomerulotubular nephritis. Aynesworth (*Amer. Jour. of Urol.*, June, 1912).

Essential or "idiopathic" hematuria is due to some form of chronic nephritis. The cases are usually treated for stone, tuberculosis, or cancer of the kidney. The lesion may, as in Albarran's case, be only as large as a millet seed. Unilateral nephritis may be the cause of the bleeding or the latter may come from one kidney in a case of bilateral nephritis. Casts and albumen are not essential in the finding of a nephritis; the presence of blood alone may be the only indication of the nephritis. A. Nelken (*Amer. Jour. of Urol.*, July, 1912).

Many cases of renal hematuria, whether associated with pain or not, will remain unexplained. It will be wise, however, to extend the search beyond the kidneys themselves; to take urine, heart, blood-vessels, blood-pressure, and the background of the eye into consideration and wherever possible couple the knowledge gained from a thorough consideration of these organs with that which is revealed by the cystoscope, though we are not to be disappointed if occasionally cystoscopy and segregation of the urine fail to supply convincing data. H. L. Elsner (*Amer. Jour. of Neurol.*, Nov., 1912).

Attention is called by the writer to the rôle played by congestion of one kidney, and the relative importance of this congestion in the etiology of that symptom, unilateral hematuria. Nephritis with its concomitant congestion is the leading feature in a majority of the cases. In a second group the bleeding is from varicosities in the pelvis, secondary to con-

gestion resulting from some extrinsic condition. In a third group the hemorrhage arises either from the rupture of a vessel or diapedesis of red blood-vessels, again secondary to congestion caused by some extrinsic condition. The actual etiological factor in any case causing the hematuria is a renal congestion, which may be certainly and successfully relieved by a nephrotomy. Alexander Randall (*Jour. Amer. Med. Assoc.*, Jan. 4, 1913).

Report of a case of unilateral hematuria in a woman 70 years of age. The onset of the hematuria was spontaneous and without apparent cause. It was not associated with any other urinary disturbance. The hemorrhage was profuse and continuous. It had persisted for four years in spite of repeated attempts by various means to control it. The hematuria was unilateral. Repeated examination of the urine failed to show any evidence of nephritis. The presence of albumin in the urine was accounted for by the blood present. No casts were ever found. P. E. Truesdale (*Boston Med. and Surg. Jour.*, Jan. 30, 1913).

The writer classifies hematuria according to its causation: 1. Traumatic, including accidental injury and also the minor traumatism resulting from stones. 2. Inflammatory, including acute nephritis, chronic inflammatory affections of the kidney, tuberculosis, acute and chronic inflammation of the pelvis of the kidney, ureter, bladder, prostate, and also of the urethra. 3. Vascular, blood dyscrasia, such as hemophilia, etc.; nevi, venous obstruction of the kidney; varicosity of the vesical veins, especially that due to prostatic engorgement. 4. Chemical, in which class should be placed hemorrhages from irritating drugs, as turpentine, cantharides, etc. 5. Toxic, in which the hemorrhage was the result of vascular changes occurring in severe toxemias, such as those resulting from malaria, acute yellow atrophy of the liver, yellow fever, scurvy, etc.

6. Neoplastic. 7. Parasitic. Renal hematuria was probably the form most interesting to the surgeon. Laceration of the kidneys, gunshot or stab wounds, frequently caused hemorrhage which appeared in the urine. J. G. Sherrill (N. Y. Med. Jour., Oct. 11, 1913).

Bacterial infection, particularly colon bacillus, is not infrequently a cause of unilateral bleeding. Billings reports 2 cases of this type, both of which were cured by the injection of colon vaccines, thus proving the etiology. Elliott also believes that the colon bacillus can induce a painless hematuria. White coincides with these writers as to the etiological importance of the colon bacillus.

In 11 cases of "essential" hematuria the writers always found an overgrowth of connective tissue, caused probably by localized inflammation, at the corticomedullary junction in the kidney. Sections showed thrombosed and even ruptured veins. If **styptics** to the renal pelvis fail, **nephrotomy** should be done. Cure resulted in each of 8 cases. Payne and MacNider (Jour. Amer. Med. Assoc., Sept. 23, 1916).

Parasites (*Distoma hematobium*, *Filaria sanguinis*, echinococcus); also more rarely acute nephritis, especially scarlatinous. In Bright's disease hematuria is observed also when malignant neoplasms are present. Renal hematuria may be caused by scurvy, hemophilia, etc.; it occasionally accompanies infectious diseases, such as variola, morbilli, scarlatina, typhoid fever, cholera, exanthematous typhus, recurrent fevers, yellow fever, erysipelas, etc.; it is rarely seen in syphilis, but in intermittent fever it is a frequent symptom (see **MALARIAL FEVERS**).

Family of 17 persons, of three generations, 10 of whom suffered from attacks of hematuria. There was no history of hemophilia in the family. Six children of the last generation all suffered from hematuria, in all probability, ever since birth. The attacks were accompanied by fever, and might be brought on by slight colds. J. Aitken (Lancet, Aug. 14, 1909).

Analysis of 13 reported cases from the literature. The writer finds that in 6 the hematuria was due to adhesion of the appendix to the ureter. In 3 the inflammatory process involved the kidney; in 2 cases the hematuria was ascribed to toxemia, and in the remaining 2 no cause could be discovered. He reports 2 additional cases. A. von Frisch (Wiener klin. Woch., Jan. 4, 1912).

The writer has encountered a case of pregnancy hematuria, blood being found in the urine for a few weeks during the third month of the woman's second pregnancy. Bed rest, restriction to milk, and injection of 10 c.c. (2½ drams) of inactivated rabbit-serum had no effect on the hematuria. The blood came exclusively from the left kidney and amounted to an average of 20 Gm. a day. The patient had a valvular affection which forbade general anesthesia for decapsulation or nephrotomy, and there seemed no resource except to interrupt the pregnancy. As soon as the uterus was emptied the hematuria gradually began to subside. The writer has found 18 other cases of pregnancy hematuria on the records of his hospital. Analysis of this material confirms the view that the pregnancy is liable to induce hematuria by the active and passive hyperemia or by the autointoxication, but that this does not occur unless the kidney is already diseased. Treub (Monats. f. Geburtshilfe u. Gynäk., xxxvi, Festschrift, 1912).

Case of hematuria from tuberculosis of the patent urachus. The diagnosis was made first of an infected tuberculous cyst of the abdominal wall and it was excised. The wall of the excised cavity appeared infected. The open end of the patent urachus was found and this organ was excised, taking a portion of the mural peritoneum with it, down to the bladder fundus, where the heavy, cord-like, tubular structure widened and fused. The cord and bladder fundus for an inch on all sides of the opening were removed, and the bladder-wall was

infolded and closed with catgut sutures. After closing up the wound, the patient did well and the hematuria did not reappear. H. E. Pease and E. L. Miller (Jour. Amer. Med. Assoc., June 1, 1912).

The author's 2 patients were young men who had a history of serious hemophilic hemorrhages in previous years; in both the hematuria came on a few hours or two days after a steam-bath with massage or a super-heated-air bath. The urine filtered without leaving any sediment, so that there must have been hemolysis as well. One patient was quieted with **morphine**, and the tendency to hematuria subsided under **gelatin** internally, **ergot**, **epinephrin**, and **castor oil**. This patient died suddenly a few months later from acute heart-failure. The hematuria kept up in the other patient notwithstanding the usual measures, including subcutaneous injection of **horse-serum**. Then, at a consultation, Kussmaul's old experience was recalled: He failed constantly on account of hemorrhage, in some experiments on dogs, until he kept the dogs from drinking, feeding them abundantly, but giving them little if any water. On this **dry diet** the blood became so much thicker that there was no further tendency to hemorrhage. The writer acted on this suggestion in this rebellious case of hematuria, and the hematuria ceased as the patient refrained from fluids. He had the heroism to refrain for two weeks from drinking, and his food was prepared as dry as possible. The blood and organic juices thus became more concentrated, and contained proportionately more coagulable substance. The result was complete subsidence of the manifestations of hemophilia. O. Mankiewicz (Zeit. f. Urologie, Nov., 1913).

In some cases the hematuria is idiopathic, and is not to be explained by any of the above-mentioned etiological factors.

DIAGNOSIS.—Two factors enter into the question of diagnosis in hematuria,

the location and the character of the lesion giving rise to the bleeding.

Urethral.—The location and character of lesions giving rise to hematuria from the urinary tract anterior to the bladder may usually be determined by the aid of the urethroscope.

Vesical.—In vesical hemorrhage from trauma, the history of the case will usually enable us to make a correct diagnosis, except when the hemorrhage is caused by the presence of a calculus, as in the latter case, as well as in trauma, the hematuria usually disappears after a good rest in bed, while motion increases it. The presence of the calculus, however, may easily be made known through the use of a searcher, cystoscope, or the X-rays.

Parasitic hemorrhage may be revealed by finding the characteristic ova (e.g., *Distoma hæmatobium*) in the urine. If due to filaria the urine will be chylous.

Bacillary hematuria is revealed either by discovering the bacilli (tubercle or colon) in the urine, or by inoculating guinea-pigs. If the bleeding comes from a tuberculous ulcer, the latter may be discovered through the use of the cystoscope.

While it is usually a fact that in renal hematuria the urine is more apt to be dark than bright, there are many exceptions to the rule. The microscopic finding of pelvic or renal epithelia with red corpuscles is strong evidence that the source of the hemorrhage is renal, while the absence of pelvic and renal epithelia and the presence of bladder cells from the different layers of the vesical mucosa would strongly indicate the bladder as its source.

Renal and Ureteral.—When the kidney is the source, renal casts in the bloody urine, particularly if the casts have blood-corpuscles lying on or in them, will usually make the diagnosis clear. If we are in doubt cystoscopy and microscopic examination of the urine will reveal the origin of the hemorrhage as between vesical and renal. If the cystoscope discloses bloody urine pouring out of one or both ureters, the source may be either renal or ureteral. This the ureteral catheter will decide. If the catheter be passed within the pelvis of the kidney on both sides, and clear urine comes from one and bloody urine from the other, the lesion

is usually on the latter side and the source is the pelvis or the kidney structure. This, however, is not infallible, for often with two kidneys equally diseased by the same pathological process only one may cause bleeding. On the other hand, if clear urine comes from both catheters the lesion is in the ureter and its location may be learned by slowly withdrawing the catheters until blood appears in one or both specimens.

Hematuria of renal origin may be caused by malignant disease, calculus, tuberculosis, or nephritis.

When due to malignant disease, the patient is generally past 40 years of age, the hemorrhage is frequently profuse and is increased by exercise, but is little, if at all, diminished by rest.

For the positive diagnosis of sarcoma, large shreds of connective tissue and numerous characteristic sarcoma corpuscles must be found in the urine before ulceration occurs, perhaps by immigration, but unless they are very numerous the diagnosis is not positive unless large connective-tissue shreds are found at the same time (Heitzmann).

Renal calculus occurs early in life, and there is generally a previous history of the passing of a renal stone or gravel. Profuse bleeding is unusual. There may be no accompanying pain. The bleeding is increased by exercise and diminished by rest. The X-ray will, however, remove all doubt as to diagnosis.

Renal tuberculosis as a source of hematuria commonly occurs in early adult life, but may not until later. The hemorrhage is most often small in amount and intermittent in its appearance, although it may be profuse and continuous. Palpation will often reveal a tuberculous kidney, as it is generally enlarged and tender to the touch. There may be pain in the lumbar region.

Associated with the blood, we will find in renal tuberculosis pus and pelvic epithelia, and careful microscopic examination may reveal tubercle bacilli in the urinary sediment. Inoculation of guinea-pigs with the suspected urine will remove all doubt.

In short, by microscopic examination we first find the source and cause of the

blood in the urine, and then confirm our findings by the use of the urethroscope, cystoscope, ureteral catheter, the X-ray, shadowgraph catheter, pyelography, and tests for renal efficiency.

Report of 73 cases of hematuria of unilateral nephritis. In most of the cases with pathological changes of the kidney pelvis or papilla there was an accompanying nephritis. The nephritis was probably the cause of the pathological changes in the kidney pelvis. The differential diagnosis between hemorrhagic nephritis and neoplasm is especially considered, the main point of difference being that neoplasm is seen in patients from 40 to 70 years of age, while hemorrhagic nephritis occurs from 20 to 50 years of age; the neoplasm presents a tumor in most cases, while the opposite is true of hemorrhagic nephritis; hematuria may persist for years and no kidney tumor be present in hemorrhagic nephritis, while this is very rare in neoplasm; finally, the functional capacity in nephritis is normal, while in tumor it is decreased. The author believes that exploratory operation for diagnosis is often necessary for treatment. B. S. Barringer (*Amer. Jour. of Urol.*, May, 1912).

The cystoscope is indispensable in examining a case of hematuria, and there should be no delay in applying it. The exceptions are acute gonorrheal cystitis and prostatic hypertrophy. Portner (*Med. Klinik*, Nov. 16, 1913).

Among 238 cases the writer found a tumor the commonest cause; tuberculosis was next, then renal calculus and colon bacillus infections. In 14 the source of bleeding was determined, but neither cystoscopy nor ureteral catheterization showed its origin. In the remaining 25 neither source nor cause could be determined. Kretschmer (*Jour. Amer. Med. Assoc.*, Feb. 24, 1917).

PROGNOSIS.—The prognosis of hematuria depends on the quantity of blood lost and the gravity of the disease which causes the bleeding.

TREATMENT.—In all forms of hematuria **rest** and **cold** are the most important therapeutics, with a liquid **diet** of milk or buttermilk, and diluting drinks to lessen the tendency to coagulation and favor a soft, free stool; in bleeding from the urethra and the bladder cold may be applied by injections of **ice-water** or externally; in *bleeding from the urethra* **compression** may be useful; also astringent injections have been employed (**nitrate of silver**, 1:2000, given warm; **acetate of lead**, **tannic** or **gallic acid**, **perchloride of iron**, **adrenalin solution**, etc.); when the bleeding is accompanied by *painful micturition*, **narcotics** are recommended.

Bleeding from the *ureters, pelvis, or kidneys* is treated by **rest**, **cold**, daily intravenous (15 c.c.) or subcutaneous (30 c.c.) injections of fresh human or animal **blood-serum**, and internal medication of **calcium lactate**, **hexamethylenamine**, **secale**, **ergotin**, **tannic** or **gallic acid**, **arbutin**, **acetate of lead**, **perchloride of iron**, **adrenalin**, **fluidextracts of hamamelis Virginica** or of **hydrastis Canadensis**, 1 ounce to the pint, warmed. In *chronic cases* of hematuria the **balsams** may be tried.

The first indication, at least to the patient, is to stop the bleeding. This bleeding may be dangerous, but rarely fatal. When due to *renal calculus*, absolute **rest**; **cold**, **acidulous drinks**; **hot applications**, and, if much pain, **morphine**, from $\frac{1}{8}$ to $\frac{1}{4}$ grain (0.008 to 0.016 Gm.) hypodermically, may be given. Hemorrhage from *acute congestions* requires **hot fomentations**, **saline laxatives**, and **diaphoretics**; *vesical hemorrhage*, **cold applications** to the **hypogastrium**, with **ergot** by mouth, or **washing out the bladder with astringents**, as **alum**, 2 grains (0.13 Gm.) to the ounce (30 c.c.), after the bladder has been emptied. When due to *malignancy*, **operation** is needed at once if the disease has not gone too far. *Tuberculous disease* requires the same care as when it affects other portions of the body. *Injuries*, if not severe, require **rest** and **cold applications**; but if serious, **operation** must be attempted. *Constitutional causes* re-

quire general treatment, as in *hemophilia* the **calcium salts** are necessary. But each case requires careful examination and study, with treatment appropriate to its own peculiar needs. W. B. Gibb (N. Y. Med. Jour., June 1, 1912).

Prostatic hemorrhage may often be relieved by **opium suppositories** in the rectum and by **cold suprapubic compresses**.

A case of unilateral renal hematuria, of supposed traumatic origin, of sixteen months' duration, and without evidence of nephritis, cured by **adrenalin**. Pain was constant on the right side, the side of the injury, but the hemorrhage was from the left kidney. Adrenalin was injected through the ureteral catheter; only 1 injection of 6 c.c. ($1\frac{1}{2}$ drams) of a 2 c.c. (32 minims) adrenalin in 8 c.c. (2 drams) of sterile water was given. Some pain was caused at first, but soon disappeared, and the urine cleared up entirely in about ten days, and there was a general improvement in the patient's condition. Three months after the treatment the man was in almost perfect health. H. H. Young (Jour. Amer. Med. Assoc., May 18, 1907).

Permanent relief in *essential hematuria* is usually obtained by **renal decapsulation** or **nephrotomy**. Before this is employed, **tuberculin** should be tried as well as, usually, **turpentine** or other medicinal measures. Babcock (Monthly Cyclo. and Med. Bull., May, 1912).

Nephrectomy is contraindicated unless there is danger of death from hemorrhage; nephrotomy is always contraindicated; and if non-operative measures, such as **rest in bed**, **internal administration of turpentine**, injection of **adrenalin** into the renal pelvis, fail, **decapsulation**, or **pyelotomy**, or both are preferable to nephrotomy or papillectomy. B. S. Barringer (Amer. Jour. of Urol., May, 1912).

The great importance and the grave possibilities of even minute degrees of urogenital hemorrhage em-

phasized. No bleeding is so scanty but that it merits immediate and prompt investigation, because it may be the earliest sign of conditions essentially progressive and incurable, excepting with the aid of surgical intervention practically at the moment of the earliest possible diagnosis. The rule to follow is, therefore, that any hematuria must be traced to its source and cause without delay. Pedersen (N. Y. Med. Jour., May 3, 1913).

Conservative treatment is strongly advised, and every means of diagnosis should be tried before exploration is undertaken. The rule at the Mayo clinic has been not to advise operation unless the hematuria was so marked as to incapacitate the patient or where evidence existed which suggested the possibility of neoplasm. Exploration is not justifiable when no clinical evidence exists other than one or two spells of hematuria. In such cases ureteral catheterization or any of the various methods of renal pelvic irritation, such as overdistention, pyelography, epinephrin, etc., should first be tried. The good results obtained from **nephrotomy** justify its use, provided nothing is found wrong with the kidney on exploration. If, however, any evidence of previous infection or tissue destruction exists or if nephrotomy fails to cure, **nephrectomy** is indicated, provided, of course, that the patient's general condition warrants it and the functional activity of the other kidney has previously been ascertained. W. F. Braasch (Jour. Amer. Med. Assoc., Sept. 20, 1913).

An analysis of 33 cases showed that in most instances there is an early unrecognized nephritis or a pre-nephritic condition and that this condition may or may not go on to a progressive damage of the kidney, depending on still obscure conditions. In certain cases the primary focus of damage can be established, and when eliminated will prevent the later development of the disease. Young (Surg., Gynec. and Obstet., Nov., 1920).

When the bleeding is caused by *calculi* or by *tumors* these are to be **removed** by operation, if possible; when the blood comes from the kidneys and only *one kidney* is *diseased*, it may be necessary to **remove the diseased kidney**; in some instances only an **exploratory incision** has been made, the kidney has been replaced after a careful examination by which no reason for the bleeding was found, and the operation has resulted in complete recovery. (For the treatment of malarial hematuria see **MALARIAL FEVERS**.) L. and W.

HEMOGLOBINURIA.—DEFINITION.—Evacuation of urine containing the hemoglobin but no corpuscles. The disease is also known as **blackwater fever**, when of malarial origin.

SYMPTOMS.—Idiopathic, or paroxysmal, hemoglobinuria shows attacks and free intervals of days, weeks, or months. Two attacks have rarely been observed in one day; they are ordinarily caused by cold, especially to exposure of hands or feet (Pavy, Murri, Lichtheim, Rosenbach). The attacks last from three to twelve hours, and are preceded for a brief period by a chill or rigor, itching of the skin, languor, a sense of weight or dull pain over the kidneys, aching pain or stiffness in the legs, and nausea or vomiting. Shivering sets in and generally there is fever, with rise of temperature to 40° C. (104° F.) and still higher. The fever continues for some hours and ends with profuse perspiration. The attacks are sometimes followed by an eruption of urticaria. The urine, which was normal before the attack, becomes dark and remains so during some hours, after which it gradually resumes its normal appearance. The liver and the spleen have in most cases been found swollen and tender. After the attack the patient is exhausted for some time, with the skin and mucosæ pallid.

The general symptoms of typical attacks of paroxysmal hemoglobinuria are described by Stempel as follows: The patient is usually pale, anemic, weak, and poorly nourished, perhaps with a hemic murmur of the heart, although many of the patients are rather pale, but otherwise well and strong. Beaumetz, Murri, and Kast describe their cases as being of a healthy, rosy color. A light icterus often

exists, even in periods between attacks. In the large majority of cases certain prodromal signs precede the attack and enable the patient to foretell with certainty the approach of the hemoglobinuria. These signs are exceedingly variable, and we find drawing pains in the kidney region (Greenhone, Eichbaum); frontal headache (Rosenbach, Murri); pain in the right breast, liver, and splenic region (Boas and Struburg); pain in the kidney region, anxious feeling about the heart, sense of exhaustion (Potain); belching gas, pain in the region of the stomach (Gillespie); pain in the back and feet (Frazer); shortness of breath, cyanosis, "things turning black before the eyes," drawing in the limbs, feeling of oppression (Wolff); frequently incessant yawning; especially characteristic is a pronounced feeling of illness, weakness, and heaviness in the limbs. There is usually a slight acceleration of the pulse, without a rise of temperature. The urine up to this time is clear; in some few patients the presence of albumin can already be detected. The typical attack is almost invariably introduced by chilliness, which varies from a slight feeling of cold to a hard, shaking chill; sometimes it manifests itself only as cold feet, numbness of the fingers, or blue coloring of the field of vision (Bristance, Laycock). It is exceedingly seldom that the chilly symptoms are absent. During the shaking chill, or perhaps very soon after it passes off, the temperature rises usually to considerable height, the severity of the attack, of course, causing an extreme variation in it. The liver and spleen may be somewhat enlarged and tender, but pressure over the kidney very rarely produces pain. The attack terminates with a more or less free outbreak of perspiration; the malaise fades away, and there remains only a feeling of dullness and relaxation. This description applies to a typical attack, but often the attacks are much milder and many of these symptoms may be absent. Several authors have observed an urticaria coincident with the attack (Ballenger).

ETIOLOGY.—Hemoglobinuria can experimentally be caused by injection, into the veins of animals, of dissolved hemoglobin or of substances which disintegrate

and dissolve the corpuscles of blood, such as water, glycerin, and the salts of the bile-acids; the same results may be obtained by inhalations of arseniureted hydrogen, sulphureted hydrogen, ether, and other poisons, or by ingestion of poisons such as arsenic, chlorate of potassium, etc.; transfusion of blood or serum of another species of animal also causes hemoglobinuria.

In man toxic hemoglobinuria is caused by poisons: *i.e.*, sulphuric acid, hydrochloric acid, arsenic, chlorate of potassium, pyrogallol, naphthol, nitrobenzol, poisonous mushrooms, etc.

Green beans or their flowers, emotional stress, the odor of resin, an infusion of quassia or decoction of absinthe, and figs are credited with having brought on hemoglobinuria. In Ghiompres's fatal case it came on after eating a dish of snails. J. Cardamatis (*Grèce méd.*, vol. ii, Nos. 7-8, 1910).

The condition is frequently a slight one and may escape notice unless looked for; but apart from its mild character it is in all respects the same disease as blackwater fever and should so be regarded. All varieties, including intermediate cases between the transient and the severe and fatal forms of blackwater fever, were met with among the armies in Macedonia. Parsons and Forbes (*Lancet*, Sept. 7, 1918).

It may be caused by extensive burns, insolation, transfusion of lamb's blood, and occur as a symptom of severe infectious diseases (scarlatina, typhoid fever, diphtheria, intermittent fever, icterus). Hemoglobinuria has been observed by Winckel as a special disease of the newborn (see *NEWBORN, DISEASES OF THE*). In severe malarial fevers with icterus, hemoglobinuria has often been noticed; these fevers, known in various countries as blackwater fever (see *MALARIAL FEVERS*), occur mostly in tropical climates in the three continents; when the patient returns to a temperate climate the hemoglobinuria ordinarily ceases; the cases may be light or severe; the severe cases end lethally either by exhaustion, by complete cessation of

the secretion of urine, or by causing a uremic condition of the patient.

Hemoglobinuria is caused by dissolution of blood, *i.e.*, in scurvy, purpura, rubrum maculosus, variola hemorrhagica, and may also be seen in typhus.

Intermittent, or paroxysmal, hemoglobinuria is a distinct affection which has especially been studied in the last few years. It has commonly been observed in men, seldom in women, in connection with syphilis, malaria, and Raynaud's disease.

In a study of 12 cases of malarial hemoglobinuria, the writer made the following observations: the age of the patients ranged from 5 to 67 years; some had taken quinine, with or without phenacetin, and others had taken no drugs for some time. They prove, he thinks, the existence of 3 types of hemoglobinuria, the *spontaneous*, the quinine type, and the mixed type. Four of his patients belonged to the first group, and the hemoglobinuria was promptly cured by **quinine**. Five were of the quinine type; the hemoglobinuria came on two or three hours after ingestion of the drug and subsided about twenty-four hours after its suspension. In one case an entire family manifested an idiosyncrasy to quinine. Two patients presented the mixed form. The hemoglobinuria developed soon after a small dose of quinine and was evidently started by the quinine, but was maintained by other factors, the intensification of the symptoms on its suspension and their subsidence on resumption of the quinine justifying this assumption.

In hemoglobinuria due to quinine intoxication all the symptoms are more accentuated, while in the spontaneous form they persist longer. The spontaneous type subsides in two or three days, the mixed type lasts for three or four days, and the jaundice for the same period, while the duration of the hemoglobinuric nephritis cannot be foretold; it proved fatal in one of the cases cited. Solimena (Jour. Amer. Med. Assoc., from Gaz. degli ospedali, March 15, 1908).

As a result of clinical observation, the Wassermann reaction, the luetin test, and the serological studies in metasymphilitic disease, the authors state that it seems safe to say that syphilis is the most important, possibly the only, etiological factor in paroxysmal hemoglobinuria, but there are as yet no observations on the presence or absence of hemolysin after the disappearance of the Wassermann reaction as a result of syphilitic treatment. Cooke (Amer. Jour. Med. Sci., Aug., 1912).

The attacks, which have already been described, vary much in frequency, are usually traceable to exposure to cold, especially of hands or feet.

In a case reported by the writers it was found that any severe chilling of the patient's skin caused a temporary hemoglobinuria, drowsiness, regurgitation of food, and other minor symptoms to be mentioned later. The phenomena were produced either by a chilling of the general body surface, or, more frequently, by the mere exposure of the hands and face to cold, damp winds, or by the wetting of the feet in cold weather. The phenomena were produced experimentally in the laboratory by dipping the patient's feet in water reduced to a temperature of 9° to 12° C. (48.2° to 53.6° F.), even when the general room temperature was 27° C. (80.6° F.). Neilson and Terry (Archives of Internal Med., June, 1910).

The disease is characterized by intermittent dissolution of the red corpuscles of the blood during the attacks. Ehrlich proved this by placing a ligature around the finger of a patient and exposing it to cold; in healthy persons this procedure does not alter the composition of blood, but in patients suffering from paroxysmal hemoglobinuria the blood drawn from a finger treated in this way will be disintegrated, the blood-corpuscles will be broken up, and the hemoglobin dissolved in the serum, which therefore has a pink instead of a yellowish color.

According to the writer, the cause of *paroxysmal hemoglobinuria* is not un-

derstood; syphilis had been thought to be a causative factor, as has malaria. The latter, however, probably derived this distinction from confounding with the well-known malarial hemoglobinuria. Dapper, in 1868, advanced the view that, since mental excitement and nervous irritation sometimes produce paroxysmal hemoglobinuria, a vasomotor influence is a causative factor. Ehrlich thinks that in these subjects exposure to cold causes the development of "ferments" which dissolve the blood. Others allege that the red cells have an undue susceptibility or lack of resistance to cold. Cold is nearly always the chief provocative factor, although mental and physical exertions are sometimes the cause of hemoglobinuria.

Some of the most common causes of *toxic hemoglobinuria*: Blood transfusion from one mammal to another produces hemoglobinuria. There is also an epidemic form of hemoglobinuria of newborn infants characterized by jaundice, gastrointestinal disturbance, constipation, rapid pulse and respiration, fever, and sometimes cyanosis. Punctate hemorrhages occur on the body, and the urine contains albumin and methemoglobin. Severe burns produce hemoglobinuria and cause a tendency toward the formation of thromboses. Snake poisons induce a rapid solution of the red cells. Sunstroke has been known to cause it. Among other causes may be mentioned arseniureted hydrogen, if inhaled; poisoning by toadstools, potassium chlorate, chromic acid, carbon monoxide, pyrogallie acid, antifebrin, hydrocyanic acid nitrites, and nitrobenzol. E. G. Ballenger (N. Y. Med. Jour., July 11, 1908).

A number of points of etiological interest were brought out in 11 cases of paroxysmal hemoglobinuria observed by the writer. In 10 of the cases cold alone precipitated the attacks; in the remaining case both cold and physical overexertion were capable of bringing on a paroxysm.

In 4 of the patients there was acquired syphilis; in 7 lues was congenital. The hereditary nature of the condition was illustrated by its occurrence in a father and daughter, while in another case it was found that a sister and 2 cousins of the patient suffered from the disease. J. Matsuo (Deut. Archiv f. klin. Med., Bd. cvii, S. 335, 1912).

PATHOLOGY.—Urine.—The urine varies in color from smoky to pink or red, sometimes almost black: the color has been compared to that of porter, coffee, or port wine. The urine is usually turbid, of variable specific gravity, and highly albuminous; it deposits after some time an abundant, chocolate-colored, grumous sediment, which microscopically is seen to consist of granular hemoglobin, mixed with renal casts (hyaline and fatty), sometimes also with crystals of hematoidin, uric acid, and oxalate of lime; occasionally a few blood-corpuscles may be found. The coloring matter is not hematin nor always hemoglobin, but most frequently methemoglobin.

The quantity of hemoglobin varies exactly with the severity of the attack: The color of the urine varies from a delicate rose color to a reddish brown, brownish black, or a deep black. The hemoglobin appears as a brownish-red sediment, which under the microscope is seen as an amorphous or granular substance. The urine contains a distinct amount of albumin. Kidney epithelium, leucocytes, and, occasionally, red cells are found. Bile is said to be seldom found. There is usually a decrease in the amount of urine after attacks. Hemin appears in paroxysmal hemoglobinuria, but not to such an extent as is found in the infectious forms. E. G. Ballenger (N. Y. Med. Jour., July 11, 1908).

As to the exact portion of the renal tubule which is responsible for the excretion of hemoglobin, the writer believes that it is the epithelium of the convoluted tubules and possibly also that of the tubes of Henle, as in sections of kidneys re-

moved within a few hours of the intravenous injection of hemoglobin the casts are found to be limited to the cortex and are not seen in the large collecting tubes of Bellini. Later, however, the plugs are found in the large collecting tubules, but in these cases they have probably simply descended from higher portions of the tubules. His observations are more in harmony with the view that hemoglobin is excreted by the renal epithelium than that it is filtered through the glomeruli, and that the amount of hemoglobin eliminated into the urine is dependent on the activity of the epithelium lining the renal tubules. Yorke (*Annals of Trop. Med. and Parasitology*, Dec. 30, 1911).

It has been found by the writers that when a relatively large amount of hemoglobin is injected intravenously, hemoglobinuria appears in a very few minutes; if a relatively small quantity be injected rapidly, it may appear with choluria; even moderately large amounts slowly injected may be eliminated without the occurrence of choluria. The absence of the spleen does not appear to affect the elimination of hemoglobin by the kidneys. The writers' idea is that hemoglobinuria does not occur until hemoglobinemia reaches the level of 0.06 Gm. per kilo body weight. When this amount is surpassed hemoglobinuria occurs, and when the concentration is less than this it ceases. The liver, however, and perhaps other tissues, take up hemoglobin as soon as it appears in the serum, and deal with it regardless of its excretion by the urine. The kidneys remove 17 to 36 per cent., and the liver takes the rest to be transformed into bile pigment. If the circulation be flooded with a large amount of hemoglobin absorbed rapidly, the bile pigments cannot be rapidly enough removed, and reabsorption into the blood occurs with the appearance of choluria. The writers would thus explain those cases in which hemolysis is accom-

panied by jaundice without hemoglobinuria; the liver removes the hemoglobin so rapidly that the minimum necessary for hemoglobinuria is not reached. Nevertheless, even under these circumstances a liver may absorb a large amount of hemoglobin, so that bile formation is so excessive that jaundice appears. As a corollary to this, a very large amount of hemoglobin appears quickly in the urine until the excess has been removed, when it no longer appears, the slow elimination of the remainder by the liver causing the subsequent choluria. Pearce, Austin, and Eisenbrey (*Jour. Exper. Med.*, Sept., 1912).

Hemoglobinuria can originate from the respiratory, digestive, or cutaneous areas, from the uterus, from wound surfaces, and from the blood itself. It may be due to burns, cold, overexertion, poisons, hemorrhage, pregnancy, and infections. The elimination of hemoglobin is effected by the convoluted tubes, not by the glomeruli. The lesions which appear in the kidneys are purely degenerative, not inflammatory. The jaundice which accompanies hemoglobinuria is an absorption icterus. There is no hematogenous icterus. Miller (*Berl. klin. Woch.*, Sept. 30, 1912).

Blood.—Recent investigations tend to demonstrate the presence of a potential hemolytic toxin (hemolysin), composed of an amboceptor and complement. The complement is a normal constituent of blood-serum, while the amboceptor is the specific hemolysin. The combined action of this dual toxin on the red cells is dependent upon certain conditions, one of which is a variation of the temperature of the blood. Exposure to cold favors the union of the amboceptor to the red cells; these when carried to the internal parts of the body, where the temperature of the blood is higher, are acted upon by the complement, and hemolysis takes place, first producing hemoglobinemia and then hemoglobinuria. It is essential that the blood be first chilled and then subsequently warmed to produce hemolysis.

During the attack the number of the red corpuscles in the blood is decreased, but afterward many small red corpuscles and hematoblasts appear and the number of red corpuscles rapidly becomes normal.

It has been shown by the writers that the blood-serum of patients suffering with paroxysmal hemoglobinuria contains, during the attack, a substance which unites with the red blood-corpuscles at low temperatures and on subsequent heating at 37° C. (98.6° F.) in contact with normal serum causes their hemolysis. These observations have been confirmed by others. Widal and Rostaine have offered an explanation for the phenomenon, considering that the normal serum contains an antihemolysin which, in cases of paroxysmal hemoglobinuria, is diminished in amount, and therefore allows auto- or isohemolysis to take place. The writers now find that the antihemolytic action of the normal heated serum is no greater than that of the serum from cases of paroxysmal hemoglobinuria.

It was further shown that in some rabbits the blood-serum had the same property of making the red blood-corpuscles, when brought into contact with them at low temperatures, susceptible to hemolysis by small amounts of normal guinea-pig serum at 37° C. (98.6° F.).

They therefore conclude that their original supposition was correct. Since 3 of 5 of their cases of paroxysmal hemoglobinuria gave a history of syphilis, the authors suggest that this toxic autolytic substance may in some way be produced by a syphilitic infection. Donath and Landsteiner (*Cent. f. Bakt. u. Parasit.*, Bd. xlv, S. 205, 1907).

In a series of experiments in 1 case of paroxysmal hemoglobinuria, the writer has not been able to confirm the opinion which Widal and Rostaine expressed. In 2 cases studied the following experiments were performed: The fingers of one hand of the patient were kept for several minutes in ice-cold water. Then

blood was drawn from the chilled fingers, and for control from the fingers of the hand which had remained at room temperature. When the blood from the chilled fingers clotted, the serum which separated out was seen to be quite deeply tinged with hemoglobin. The serum above the clotted blood taken from the fingers of the other hand, although showing some hemoglobin, was never so deeply colored. Control experiments carried out in the same manner with normal individuals never gave the same results. The serum was not discolored. It was found, however, when the blood from hemoglobinuric patients was prevented from clotting, that visible hemolysis did not occur and the supernatant plasma remained free from hemoglobin. The writer believes that the red blood-corpuscles of patients with paroxysmal hemoglobinuria are easily injured by low temperatures, but hemolysis does not take place in the peripheral circulation and the injured red cells are not freed of their hemoglobin until they reach the kidney. Choroschilow (*Zeit. f. klin. Med.*, Bd. lxiv, S. 431, 1907).

The leucocytes are usually about normal. The alkalinity is slightly decreased, and, of course, there is a decided decrease in the red cells, but this is likely to be followed by a rise to normal or above in two to six days. Stained specimens during an attack are said not to show the red cells in rouleaux, and many pale and broken cells are observed. The serum may be tinged with brown. In chronic cases there is usually anemia and splenic enlargement. E. G. Balenger (*N. Y. Med. Jour.*, July 11, 1908).

The writers report 2 cases and conclude that, as the matter at present stands, we are justified only in saying that the hemoglobinemia which follows exposure to cold is due to some biological product in the plasma which in its behavior admits of the demonstration of every step in

hemolysis as expounded by the side-chain theory of Ehrlich. Hoover and Stone (*Arch. of Internal Med.*, Nov., 1908).

In a study of 4 cases of paroxysmal hemoglobinuria, confirming the work of Donath and Landsteiner, and Hoover and Stone, the writers demonstrated the autohemolysin described by Donath and Landsteiner in all of their cases. In some instances this has been missed by other observers, but the authors find that these negative results are probably due to the fact that often, and especially after a paroxysm, the complement is largely, if not quite, exhausted in the patient's blood. Hemolysis may, however, always be obtained by adding fresh complement. Local lowering of temperature leads to the formation of new complement in the body, probably locally, so that one attack does not prevent an early recurrence of the attack. A few days after a paroxysm the blood contains the normal amount of complement. During the paroxysm both systolic and diastolic blood-pressures rise, even before the chill, to decline with the height of the fever. Between attacks there is a lymphocytosis of from 30 to 35 per cent. During an attack the lymphocytes are diminished to 9 or 10 per cent., the decrease being parallel to the severity of the attack; at the same time the eosinophiles diminish or disappear from the blood. The dissolved hemoglobin is excreted partly as urobilinogen. The hemolytic amboceptor is bound to the red blood-cells during cooling; it can be separated from them by repeated washing with warm normal saline solution. The red blood-cells of patients with this disease are less resistant to changes in temperature and to dilute acid and dilute saponin solutions than those of a normal individual. Toward cold alone they are not more sensitive. Against the patient's hemolysin, however, his own red blood-cells are more resistant than normal red corpuscles, which are usually aggluti-

nated by the patient's serum. The serum of the hemoglobinuric possesses hemopsonins, since it causes normal macrophages to phagocyte red blood-cells. Meyer and Emerich (*Deut. Archiv f. klin. Woch.*, Bd. xcvi, S. 287, 1909).

Report of a case of paroxysmal hemoglobinuria in a man of 48. Hemolysins were found in the blood, and their presence in the blood accumulating in the viscera in consequence of the exposure to cold, with the local accumulation there likewise of carbon dioxide in the blood, produce conditions similar to those of Hyman's test-tube experiments. Hemolysis follows and the hemoglobinuria results; the whole process can be broken up by putting an end to the action of cold by warming the legs. The Wassermann reaction was positive in this patient, which possibly throws light on the unusual lack of resistance to carbon dioxide on the part of the red corpuscles. Krokiewicz (*Wiener klin. Woch.*, April 6, 1911).

The serum of patients suffering from paroxysmal hemoglobinuria was found by the writer to contain a complex hemolysin, of amboceptor-complement nature, which is capable of bringing about the solution of the patient's own corpuscles, corpuscles of other paroxysmal hemoglobinuric patients, and of all other individuals, as far as tested. Patients suffering from paroxysmal hemoglobinuria are not confined to one group, as determined by the isoagglutination reaction, and their serum may contain normal isohemolysin in addition to the hemolysin characteristic of their disease. The autoamboceptor may be absorbed from patient's serum, leaving the isoamboceptor, and conversely the isoamboceptor may be absorbed, leaving the autoamboceptor, thus enabling each to be tested separately on any given set of corpuscles. Only the amboceptor component of the hemolysin of paroxysmal hemoglobinuria is peculiar to the disease. The complement differs in no way, so far

as tested, from that present in normal serum. The amboceptor peculiar to paroxysmal hemoglobinuria differs from other known hemolytic amboceptors in that it will unite with the red blood-corpuscles only at a low temperature in the presence of complement, and, furthermore, in that it is capable of bringing about the solution of the patient's own cells (autohemolytic action) and those of other members of the group to which the patient belongs, as well as the cells of members of other groups. Hemolysis due to the autohemolysin of paroxysmal hemoglobinuria, unlike normal isohemolysis, may occur entirely independently of agglutination. The red cells of 3 patients showed a variable and usually increased resistance to hypotonic salt solution, never a resistance less than that of normal corpuscles. All 3 cases gave a positive Wassermann reaction. Moss (Bull. Johns Hopkins Hosp., July, 1911).

In his experiments the author noticed that the corpuscles of patients suffering from paroxysmal hemoglobinuria were somewhat less resistant to an atmosphere of carbonic acid gas, as compared with corpuscles from a normal individual. This difference was not very marked, however. The chief difference lay in the blood-serum of the patient.

Contrary to the findings of Hyman, it was found that normal corpuscles in normal salt-water suspension were also, although more slowly, hemolyzed in an atmosphere of carbonic acid gas. Sodium citrate solution, strength 1.5 per cent., was sufficient to prevent hemolysis of both the patient's and normal human corpuscles in an atmosphere of carbonic acid gas at room temperature. Apparently the salt concentration of the blood-serum is the factor which determines whether the corpuscles shall be hemolyzed or not. Normal serum has sufficient salt dissolved to prevent hemolysis of both the patient's and normal corpuscles in an atmosphere of CO₂ at room tempera-

ture. The paroxysmal attacks have been variously ascribed to the action of cold, congestion, and trauma, locally or remotely produced. It would appear that local changes in the tissues must be necessary before a state of hemoglobinemia or hemoglobinuria can be produced. In view of the fact that cold, trauma, and passive congestion may all lead to an attack, and since the three conditions are associated with the production of an excessive acidity of the tissues, it is not unreasonable to suppose that the organic acids thus formed play some part directly in the production of the attacks. The corpuscles may be less resistant, they may be subject to the action of a specific hemolysin, and yet an additional factor acting locally in the tissues seems necessary for an attack to be produced. In the presence of the proper salt concentration, the corpuscles are protected against the hemolytic action of any organic acids. This naturally suggests the giving of neutral salts as a therapeutic agent, to prevent the onset of attacks in patients suffering from paroxysmal hemoglobinuria. O. Berghausen (Jour. Amer. Med. Assoc., from Arch. of Internal Med., Feb., 1912).

In 11 cases of paroxysmal hemoglobinuria observed by the writer, serologically, all exhibited autohemolysis after the original method of Donath and Landsteiner, though in some instances complement was exhausted, and it was necessary to add it before hemolysis occurred. The autohemolysis was less pronounced the oftener the attacks of hemoglobinuria. Variation in the autohemolysis was dependent not only upon differences in the quantity of complement, but also of autohemolysin. In 45 per cent. of his cases, the writer demonstrated isohemolysins in the blood. Usually, the red blood-corpuscles of a hemoglobinuric whose blood contains isolysins are protected from the action of the isolysins of a second patient. J. Matsuo (Deut. Archiv f. klin. Med., Bd. cvii, S. 335, 1912).

Case of paroxysmal hemoglobinuria in the blood-serum of which, either constantly on exposure to cold or else brought into existence by cold, exists a substance which hemolyzes the red blood-cells. This gives rise to a hemoglobinemia, which in turn provokes the phenomena of a paroxysm very much like that provoked by the loosing of hematin by the action of the malarial parasite. The excretion of the hemoglobin in the urine by the kidneys is one of the most striking of the phenomena and gives the disease its name. This autohemolytic substance in the blood is in all probability the result of infection by the *Spirocheta pallida*. On the other hand, the possibility exists that the same substance which is produced by the organism of syphilis and to which the name of antibody is given and which produces fixation of complement, thus giving a positive Wassermann, is produced by some other agency in the disease under discussion. Thus, there may exist a positive Wassermann without syphilis. The existence of this same substance, which gives rise to hemolysis, in parasymphilitics, so-called, makes it highly probable that the etiological factor here, too, is syphilis. It is quite possible that hemolysis may take place in the menstruum of the parasymphilitic, and that it is an increased permeability in the hemoglobinuric which gives rise to actual hemoglobinuria. W. W. Young (Jour. Amer. Med. Assoc., Jan. 31, 1914).

Paroxysms.—The paroxysms, in some cases at least, are caused by the presence of parasites in the blood; in animals (oxen, horses) a similar disease has been observed. Krogins and von Hellen found in the blood of diseased oxen parasitic corpuscles analogous to the plasmodium of malaria.

DIAGNOSIS.—The presence in the urine of hemoglobin, or more correctly of methemoglobin, may be demonstrated by different tests, as Heller's test, the guaiac test, the microscopic examination, and spectral analysis (see HEMATURIA).

By spectral analysis two absorption bands are found between *D* and *E*, and a third between *C* and *D*, of the Fraunhofer lines.

Raynaud's disease is thought by some observers to be closely related to paroxysmal hemoglobinuria. When these diseases are found combined the symptoms of either may dominate the clinical picture. Raynaud's disease begins as blotches, symmetrical in arrangement and paroxysmal in character. There is also local syncope, asphyxia, or hyperemia. Trophic disturbance finally begins as an almost symmetrical dry gangrene. Pain is most excruciating. The disease may exhaust itself in a single attack, or renewed attacks may continue for years. It occurs more frequently in women than men, while the reverse is true of paroxysmal hemoglobinuria. There is often a decided difference in the temperature of individual fingers. The cause is usually cold or toxic influence—occasionally traumatism or malaria. E. G. Ballenger (N. Y. Med. Jour., July 11, 1908).

A new principle is applied by the writers to determine hemoglobin percentages. It is based on the fact that when fluid of one color is inspected through a screen of another color the thickness of the screen determines whether the color of the screen or the color of the fluid behind it is perceived by the eye. The receptacle containing the blood, diluted to 5 per cent., is inspected through a screen, which is a long, hollow, tapering wedge, containing green gelatin. This hollow wedge is moved along over the vessel containing the blood, which is readily seen through the thin layer of green in the tapering end of the wedge-vessel, but as the thickness of the layer of green increases, toward the broad end of the wedge, there comes a point where the blood can no longer be seen, the eye perceiving merely the green interposed. In the apparatus constructed for the purpose the screen is covered, except for two slits, and as the screen is moved along it reaches a point where

through one slit the red blood is still visible, while through the other slit, 5 mm. beyond, only green can be perceived. The point between the slits is accepted as the index of hemoglobin percentage. This same principle can be applied as a test for the percentage of indican, acetone, acetic acid, etc., but it is important to select a color for the contrast which is transparent for rays of the same wave-length, but which appear to the eye as another color. This method of determining the hemoglobin percentage is proving accurate and free from the influence of the personal equation. Schlesinger and Fuld (Berl. klin. Woch., May 1, 1911).

PROGNOSIS.—In the hemoglobinuria caused by poisons, infectious diseases, septic diseases, etc., the prognosis is determined by the gravity of the primary disease; intermittent hemoglobinuria is for a long time compatible with life; the patients never die during an attack; recovery has been observed, but often the disease continues for many years.

TREATMENT.—When hemoglobinuria is a symptom the treatment must be directed toward the fundamental disease; in cases connected with syphilis an **anti-syphilitic treatment** has been of use, as well as **quinine** in hemoglobinuria of malarial origin.

In paroxysmal hemoglobinuria **change of climate, dietetic treatment, iron, quinine, and arsenic** have been recommended.

In 9 severe cases of hemoglobinuric fever in chronic malaria, the writer employed the following treatment: Subcutaneous injection of **salt solution** every six hours, with the same by rectum twice a day; **wet cupping** to the lumbar region; from 5 to 8 Gm. ($1\frac{1}{4}$ to 2 drams) of **calcium chloride** during the day; restriction to a **milk diet**, and complete **abstention from alcoholic drinks**. The patient was kept in a **warm bed**. If hematozoa are found in the blood, or if paroxysms recur, he gives 1 Gm. (15 grains) of **methylene blue** a day, in four doses, keeping this up for ten days, and then commencing cau-

tiously with **quinine**, 0.1 Gm. ($1\frac{1}{2}$ grains) every two or three days. If no fever follows this the dose is gradually increased until the patient is taking 1 Gm. or 1.25 Gm. (15 to 19 grains) of **quinine** a day. This is kept up for several days, by the end of which time the patient is not only cured of his hemoglobinuric fever, but also of the malaria as well. Cardamatis (Jour. Amer. Med. Assoc., from Grèce méd., vol. viii, Nos. 17-20, 1907).

Report of 4 cases of blackwater fever treated by the writer by Vincent's method, viz., with **calcium chloride**. But little can be concluded from a report of only 4 cases; but as there were 2 deaths and 2 recoveries, he failed to derive the benefits claimed by Vincent. A more extended trial is recommended. W. H. Deaderick (Jour. of Tropical Med. and Hyg., Dec. 16, 1907).

The **prophylaxis** consists chiefly in **avoiding exposure to cold** and in acquiring an immunity to its effect by suitable hardening measures. When possible the patient should live in a **warm climate** and wear **flannels** during chilly weather. The therapeutic measures are based upon many different theories, according to the view as to its cause. Quinine was administered before it was shown that paroxysmal hemoglobinuria was not dependent upon malaria. Food containing oxalic acid was forbidden by Robin on account of the frequent excessive secretion of calcium oxalate. **Tonics, iron, and a nourishing diet** are necessary when the patient is anemic and weak. E. G. Ballenger (N. Y. Med. Jour., July 11, 1908).

As **cholesterin** seems to have an inhibiting action on hemolysis in the test-tube, the writer applied it to arrest paroxysmal hemoglobinuria and found that it did actually abort the attacks and ward them off as long as the system was under the influence of the cholesterin. On its suspension the attacks recurred as before. He gave the cholesterin in five intramuscular injections of 5 c.c. ($1\frac{1}{4}$

dram) each time of a 10 per cent. emulsion of cholesterin, in the course of eleven days. Exposure to the same cold and other external influences, which before had brought on a severe attack of hemoglobinuria for eight or ten hours, induced only a slight elimination of hemoglobin, lasting only two and a half hours. Another time the characteristic chill and fever followed the exposure, but there was no hemoglobinuria. A week after suspension of the cholesterin the same exposure brought on a severe and typical attack. No appreciable changes could be detected in the blood during the cholesterin treatment. The patient had no complement in the blood, but complement from healthy blood showed no influence from cholesterin. Pringsheim (Med. Klinik, Feb. 16, 1913).

The writer emphasizes the uselessness of hemostatic agents in this condition. Since it is due to hemolysis, or rather, hemoglobinolysis, he was led to employ instead a remedy exerting a conserving, reparative influence on the red blood cells, viz., **arsenic**, in intravenous injections. In the first five patients thus treated—three already in a grave condition—two injections cleared up the urine and caused prompt convalescence. Subsequently the following combination was used: **Colloidal arsenic**, 0.00034 Gm. ($\frac{1}{200}$ grain); **colloidal iron**, 0.00012 Gm. ($\frac{1}{500}$ grain), and **water**, 2 Gm. (30 grains). Twenty-three patients received such injections, without any other treatment. The combined series showed 28 cases with 1 death, or 3.57 per cent., as against the usual mortality of 33 per cent. The single unfavorable case was that of a little girl of 8 years in whom no intravenous injection could be given, and who received only intramuscular injections, which are ineffectual. As soon as fever and hemoglobinuria appear in a malarial patient, an injection of iron and **arsenic collobiase** should be given, followed by another injection the next morning. The urine now generally clears

up, but for safety a third and last injection is given. Beginning the fourth or fifth day, **adrenalin** is administered for about a week. During convalescence, malarial paroxysms sometimes appear. These are satisfactorily overcome by intravenous injections of quinine **collobiase**. R. Roux (Presse méd., July 25, 1918).
L. and W.

HEMOPERICARDIUM. See
HEART AND PERICARDIUM, DISEASES OF.

HEMOPHILIA.—DEFINITION.
—Hemophilia is an inherited or acquired disorder of the blood, characterized by an abnormal liability to severe and sometimes uncontrollable hemorrhages.

SYMPTOMS.—The condition is generally discovered by accident, a slight wound, the extraction of a tooth, the application of a leech, vaccination, etc., being followed by profuse and sometimes dangerous bleeding. Epistaxis is of frequent occurrence. In 334 cases collected by Grandidier from the literature, it was the leading symptom in 169 instances. In women epistaxis is especially common, because the hemophilic process mainly manifests itself through the mucous membranes; menorrhagia, metrorrhagia, post-partum hemorrhage, etc., are also frequently suffered from. According to Kolster, however, pregnancy and labor do not present the danger for an hemophilic woman that might be supposed. Of 130 cases, the death of the mother occurred only in 3 and abortion in only 16 cases.

Seven cases of hemophilia in which uterine hemorrhage was marked. One case proved fatal. The writers found 151 recorded cases of hemophilia in women, 46 of which they consider doubtful. Of the 151 cases

a family history of hemophilia was obtained in 99 cases, excluded in 34, and doubtful in 18. They do not find that hemophilia necessarily makes its appearance with the establishment of menstruation, nor that this function is always of grave danger in such women.

At least 100 cases of pregnancy complicating hemophilia are recorded. Only once was there hemorrhage before the expulsion of the placenta. In 56 cases the hemorrhage was severe and in 5 fatal. Severe hemorrhages need not necessarily be expected at the time of labor, but there seems to be an increased tendency for hemorrhages late in the puerperium. L. Frankel and L. Böhm (Monats. f. Geb. u. Gyn., Bd. xxx, 417, 1909).

Again, it does seem to interfere with normal development. Comby refers to the case of a girl aged 11 months in whom from the third week of life there had been continuous and spontaneous hemorrhages from the nose, mouth, and rectum, and into the substance of the skin, without, however, impairing in any manifest way the child's development.

It may simulate purpura. The skin may be the seat of hemorrhage-forming dermatomata or ecchymoses in circumscribed areas. This is especially the case after a pinch, a blow, etc., or they may occur without provocation. Eruptive fevers, especially scarlatina and varicella, may provoke them.

Hemophilia is chiefly distinguished from purpura by the tendency to *traumatic* hemorrhages, while in the latter the hemorrhages are nearly always *spontaneous*. The writer distinguishes between hemophilia proper, a hereditary disease, and the hemophilic state, symptomatic of a general transitory infection or intoxication. M. Guillain (La Clinique, June 2, 1911).

There frequently occurs in hemophiles a sanguineous infiltration in the iliac fossa, particularly in the sheath of the psoas iliacus, which has produced symptoms that have led to an operation for a suspected appendicitis. They occur, however, in other than hemophilic subjects. In operating, the writer has found, for instance, an appendix completely separated from the cecum, the artery having ruptured during the process and so produced the blood-tumor. Schwartz (Paris Méd., Oct. 12, 1912).

The hemorrhages may be internal, considerable blood being evacuated from the intestinal canal, the bladder, etc., and hemophilia may cause cerebral hemorrhage by producing extravasations, though it is probable that in these cases there also exists a concomitant vascular disease. Reddish striæ of minute dilated vessels are sometimes noted on the skin.

There are two types of apoplexy in hemophiles. One due to trauma, including injuries not readily demonstrable. Conceded the friability of the cerebral vessels, the nature of the injury is of secondary significance. A mild, blunt injury may be sufficient to cause a trauma. This is also seen in joint injuries. In the other type the hemorrhage is termed spontaneous, for want of evidence of trauma of any kind. Hauck (Münch. med. Woch., May 27 and June 3, 1913).

Hemorrhages into the joints and periarticular tissues are common. In men arthritic symptoms are frequently observed, especially during cold and damp weather, the knees being most prone to pseudorheumatic manifestations, which are sometimes accompanied by fever. The joint symptoms are often the precursors of an approaching hemorrhage. They may be attended with swelling of the joint and pain, and give rise to fever, thus simulating rheumatism.

Hemophilic diseases of the joints may be divided into two classes: the spontaneous and those caused by a violent effort. The spontaneous is the only true form of hemophilic joint disease; in the other the joint manifestations may be present in normal individuals, but greatly aggravated when the hemorrhagic diathesis is present. It differs from the other form: 1. In the cause; in the spontaneous appearance, without any, or only a slight, traumatism, or a long walk, in the other following a serious injury. 2. In the time of its appearance, coming on slowly, five or six hours after the walk or slight effort in the former, immediately in the latter. 3. In the acuteness of the symptoms, which are moderate in intensity in the spontaneous, but considerable in the other form. 4. In the duration of the acute period, which is generally about eight days, rarely more than fifteen, in the spontaneous, and from fifteen to eighteen in the traumatic. 5. In the course and result, *restitutio ad integrum* being the rule in the spontaneous cases, except in the chronic form, while pseudo-ankylosis is apt to persist in the traumatic cases. Cruet (*Presse méd.*, Sept. 9, 1908).

Arthropathies may be classified as (1) simple hemarthrosis; (2) subacute arthritis, or (3) chronic arthritis. The first appears rather suddenly. The joint is swollen and tender and is immobilized in semiflexion. There is a local rise of temperature as well as constitutional, 38° to 39° C. (100.4° to 102.2° F.). There is fluctuation, and exploratory puncture shows a sanguineous exudate. The X-ray shows normal articular surfaces. The course is seven to eight days. This condition is not infrequently followed by muscular atrophy. The second and third are accompanied by atrophy of the muscles, are painful, and leave the joints in a damaged condition. Another not infrequent symptom is hematoma in the psoas muscle. The onset is sudden and painful. The leg is held in

outward rotation, flexion, and abduction. Tumefaction in Scarpa's triangle, sensory disturbances, and paralysis of the quadriceps occur if the crural nerve is compressed. The diagnosis can only be affirmed by examination of the blood. Gullain (*La Clinique*, June 2, 1911).

Three stages of joint troubles are observed in hemophilia: (1) of hemarthrosis; (2) inflammation, and (3) stage of retrogressive changes with deformity. The painless, sudden onset in pale young men marks the first stage. Hemorrhages in the skin complete the diagnosis. The second stage is strikingly similar to the white swelling of tuberculous arthritis, and has led to mistaken diagnosis, 2 of 3 cases observed by Koenig having suffered death in consequence, from hemorrhage after operation.

Hemorrhages from mucous membranes may be so profuse and prolonged as to prove fatal. When they can be arrested, recovery is, as a rule, prompt when the loss of blood has not been too severe; otherwise anemia may persist. Recurrent epistaxis should always awaken suspicion; the capillaries ooze blood.

The tourniquet sign of disease with hemorrhagic manifestations is an aid to ascertain whether hemophilia is present. A constricting band is applied to the limb above, not drawn tightly enough to induce actual arterial hyperemia, but merely enough to cause the veins to be a little more prominent. Any tendency to a hemorrhagic diathesis is then rendered locally evident. The disease does not seem to be with the blood itself so much as in the walls of the vessels. In some of their patients a slight traumatism at one point was followed by hemorrhagic manifestations all over the body except the face, and no means could be devised to induce them in the face; evidently

the vessel walls here are exceptionally strong. C. Frugoni and F. Giugni (*Semaine méd.*, Jan. 18, 1911).

While the leucocytes may be considerably increased, the predominant characteristic of the blood is the relative length of time it takes to coagulate when drawn. Instead of the normal five to six minutes, the coagulation time may be extended many minutes and even hours.

ETIOLOGY AND PATHOGENESIS.—The prevailing belief that the tendency to hemophilia is transmitted through the female line only (Nasse's law) cannot be said to be universal, though nearly so, Kolster having shown that there were exceptions. Hoessli refers to a family in Switzerland in which hemophilia can be traced back three centuries. While it included male bleeders, the females, as a rule, remained exempt, but they transmitted the disease to their male offspring.

History of a family of hemophiles in which the disease was traced back four generations. The transmission had in every case been through the female. W. M. McCabe (*So. Med. Jour.*, Dec., 1909).

Study of hereditary hemophilia under conditions of tenure of a Carnegie Research Scholarship. Twelve patients were examined descended from 6 different hemophilic stocks in Scotland, England, and Germany. In none of these families had there been any known instance of a departure from the characteristic type of transmission, *i.e.*, from the females to the males. The results showed that there is a delay in the coagulation of hemophilic blood, a delay which in some cases is very pronounced—over one hour in some—and which far exceeds any retardation of coagulation observed in other disease. Addis (*Quarterly Jour. of Med.*, Oct., 1910).

The writer recalls the extreme infrequency of hemophilia in the female. In the celebrated Mampel family, 4 generations of 212 individuals, there were 37 bleeders, all males. In certain individual statistics, however, 10 per cent, and even more have been of the other sex. Castex (*Med. Rec.*, Nov. 25, 1916).

The rarity of hemophilia in adults is attributed to the tendency for hemophilic children to succumb before reaching maturity and to the blood of survivors acquiring the proper power of coagulation. The patients are usually under 15 years old and of the male sex; a history of traumatism; indolence and benign nature of lesion; presence of subcutaneous hematomata; absence of adenopathy; radiographic findings and the hemophilic family history. Madero (*Rev. de la Asoc. med. Argentina*, Oct., 1917).

Such families are often large, and the disease seems to have a predilection for blondes. It is said to be more common in German countries and among Jewish people, but it has been encountered in all civilized countries, including, particularly, the United States. According to Virchow, 7 men are affected to 1 woman.

Case in which the inheritance came through the father, who was himself a bleeder. This is the first case, so far as the writer knows, of typhoid fever reported in a bleeder. It showed that such may be brought to a successful termination in a patient so afflicted. No hemorrhages occurred from the intestinal lesion. The successful termination was probably in large measure due to the fact that at or about the age of 40 the hemorrhagic tendency abated. Larned (*Amer. Jour. Med. Sci.*, March, 1910).

The cause of hemophilia, and of the characteristic slowness of the blood to coagulate, has been shown by many investigators to be due to deficiency of thrombokinase in the blood-cor-

puscles, and therefore in the blood fluids. As it is this substance which endows the blood with its power to coagulate, this property is compromised in proportion as the deficiency of thrombokinase is marked. Hemorrhages do not cease, as in normal individuals, because the formation of the clot is thus prevented.

[In 1907 I ascribed the coagulating power of the blood mainly to the adrenal secretion, which I held penetrated the red corpuscles in the lungs. Thrombokinase, since found to be contained in the same corpuscles, is probably the adrenal product which I then termed "adrenoxidase." S.]

Howell states that in normal individuals the cellular elements of the blood and the wounded tissue produce thrombokinase, that thrombokinase + calcium + thrombogen form thrombin, and that the union of thrombin and fibrinogen forms fibrin.

According to Hammersten, a proteid of a globulin type called fibrinogen is held in solution by plasma. This proteid, being an end-product of the white cells, further disintegrates when withdrawn from the body, forming the nucleoproteid or prothrombin. When calcium salts act on this, we get the fibrin ferment or thrombin. When thrombin comes into contact with the fibrinogen molecule dissolved in the plasma, it splits into two parts—one a globulin of no importance, and the other an insoluble fibrin which entangles the cells in the blood, so essential to clot formation. Hence, according to Hammersten, coagulation depends on calcium, which converts prothrombin into thrombin, fibrin ferment and fibrinogen in solution.

The coagulation of hemophilic blood is increased by the addition of

defibrinated blood which has been rendered fibrin-ferment-free by heating to 60° to 62° for half an hour. This points to thrombokinase—not thrombogen—as the substance which is decreased in hemophilic blood. Normal blood-serum, after removal of fibrin ferment by heat, also accelerates the coagulation of hemophilic blood, though less strongly, indicating that thrombokinase is normally to a certain extent excreted by the corpuscles into the serum during coagulation. Normal corpuscles washed ferment-free strongly increased the coagulability when added to hemophilic blood, while similarly prepared hemophilic corpuscles produced a like but very slight effect. Hemophilia is, therefore, a disease due to a decreased content, or decreased availability of the thrombokinase, in the blood-corpuscles. Whether this is an anomaly of the erythrocytes, leucocytes, platelets, or of all three is uncertain. Sahli (*Zeitsch. f. klin. Med.*, Bd. lvi, 1905).

The delay in the coagulation time is to be attributed to insufficient formation of the fibrin-ferment factors, especially the thrombokinase, which is derived from blood-platelets and leucocytes. That this is the only etiological feature of importance they do not assume. By means of suction applied to the skin of the back they were unable to demonstrate any greater liability to hemorrhage in their patient than in 3 normal adults examined. Morowitz and Lossen (*Deut. Arch. f. klin. Med.*, Bd. xciv, S. 110, 1908).

Careful examinations of the blood of three hemophilics, with controls founded upon similar observations on those otherwise diseased and also those in health. The writers found a decrease in the viscosity of blood. Whereas the fibrinogen and the thrombogen were present in normal amounts, the thrombozyme was variable in quantity, in some cases being normal and in others diminished. This discrepancy was ascribed by them to a qualitative change in that

ferment, which possesses a diminished affinity for the thromboplastic substances, which are in turn present in normal ratio. The thrombozyme is always unstable and degenerates after the blood is drawn. It is a significant, if not conclusive, fact that old plasma from a normal individual is identical in its activity to freshly drawn hemophilic plasma. They consider that the salts of calcium and the anticoagulating substances from the liver play a very insignificant rôle in clotting. In a word, the most important element is the thrombozyme, which is sometimes diminished quantitatively, but is always altered qualitatively. Wolff and Herry (Boston Med. and Surg. Jour., Feb. 17, 1910).

The coagulation of blood flowing from a wound is induced by thrombokinasé added to it from the tissues, and the rapidity of coagulation varies directly with the amount of this thrombokinasé. Much larger quantities of thrombokinasé are required to produce rapid clotting in hemophilic than in normal blood. In a wound in a hemophilic, coagulation may therefore only occur in those parts where the concentration of thrombokinasé is highest, *i.e.*, on the sides of the wound. Addis (Quarterly Jour. of Med., Oct., 1910).

Case in which a careful study of the blood was made, and stress is laid on the presence of a marked leucocytosis (35,000), with a relative and actual increase in the lymphocytes (42 per cent.), and an actual increase in the eosinophiles. Leclerc and Chalié (N. Y. Med. Jour., from Lyon méd., Oct. 13, 1912).

The writers were impressed with the essential rôle of the platelets in 2 cases. Whereas addition of normal platelets to hemophilic plasma caused it to coagulate in normal time, hemophilic platelets, added in amounts 75 times as large, never reduced the coagulation to anywhere near normal. The delay in coagulation in hemophilia occurs in the initial step in clotting, which seems to be a render-

ing of the platelets available by some process resembling solution. Minot and Lee (Arch. of Internal Med., Oct., 1916).

Hemophilia has been ascribed to a deficiency of calcium salts; but while it has been shown by Addis that variations in the percentage of calcium have but little influence on the coagulation time, the clinical use of calcium has not proved of much value.

PATHOLOGY.—Lesions have also been found in the vascular walls, affecting especially the middle or muscular layer. According to Kuhlmann, the changes are such as to seriously compromise the anatomical and physiological functions, but it is probable that these are, in most cases, due to concomitant diseases, the lesions corresponding with the coagulation necrosis of tuberculosis, syphilis, and other general disorders.

PROGNOSIS.—Hemophilia is particularly to be feared when it occurs in children in an aggravated form. Through modern methods of treatment, however, its baneful effects may, when the disorder is discovered early, be forestalled in most instances. In slight cases the disease frequently disappears at puberty. The hemorrhages are usually more dangerous in boys than in girls; uterine hemorrhages, though copious, seldom endanger life.

TREATMENT.—The prophylactic treatment of hemophilia consists mainly in the avoidance of exciting factors. The extraction of teeth should especially be guarded against and preference be given to other measures, such as gradual loosening and eviction with rubber, of a tooth, rather than to the forceps. Scratches, cuts,

etc., should be avoided; hence an occupation exposing the sufferer to solutions of continuity becomes dangerous. Violent exercise is occasionally the only exciting factor.

Inasmuch as the daughter of a bleeder transmits hemophilia to her sons, while her daughters, though themselves not bleeders, transmit the disease to their sons, females who belong to hemophilic families and males who suffer from the disease should not marry. As a rule, severe cases of hemophilia—which usually begins about the second year—do not survive childhood. Hence, it is in a measure a moral crime to beget such children.

Having to operate in 2 cases of threatening appendicitis in men of 19 and 40, the operation was done only as the last resort and under every precaution. Neither patient survived the excessive loss of blood. Marriage should be forbidden to persons liable to beget bleeders, especially the women in a hemophilic family, whether they are themselves bleeders or not. This prohibition need not extend to the male members of the family if they are free themselves from the tendency to hemophilia. The general health of a hemophilic child should be kept constantly at its highest point, and the attendants, teachers, and mates of the child should be instructed to ward off trauma of all kinds. Dahlgren (Hygiena, June, 1908).

Hydrastis canadensis has proved useful as a prophylactic, but only in large doses, 10 to 15 drops of the fluid-extract three times a day. Sir A. E. Wright recommends **thymus gland**, while Fuller, Sajous, and others have found **thyroid gland** very useful as a prophylactic. The latter is of great advantage to prepare a hemophilic patient for operation; 3 grains (0.2

Gm.) of the desiccated gland three times a day gradually raises the coagulating power of the blood sufficiently to permit even a serious operation, nephrectomy for example, as observed by W. H. Taylor.

The various preparations of **iron** have been recommended; **ferratin** is probably the most useful preparation at our disposal. The **perchloride** has been recommended by Legge. **Strychnine** is indicated on account of the involvement of the vasomotor system. **Saline purgatives**, by reducing the arterial tension, are valuable when prodromic symptoms are noticed.

Case of a woman who, because of hemophilia, suffered from very excessive anemia. She was treated by the various hemostatics, and by repeated injections of ergotin, without much result. Finally 3 capsules of **thyroid gland** were given each day, with the result that the loss of blood was immediately arrested. The patient gained in weight, the purpuric spots disappeared, the gums became firm, and some color began to appear in the face. Cardiac palpitation was decreased. At no time was the dose greater than 3 capsules a day. Delace (Jour. de méd. de Paris, Jan. 23, 1898).

Case in which the patient ultimately became very anemic. Finally **thyroid extract** was given in doses of 5 grains (0.3 Gm.) each three times a day. The good effect was noticed at once by lessening of pain, which had hitherto been severe, and diminution in loss of blood. In eight days bleeding had ceased. Rugh (Annals of Surg., May, 1907).

Case of a boy of 11 years, descended from a hemophilic family, who had a severe hemorrhage, following the loss of a milk-tooth. The alveolus was tamponed with a piece of gauze saturated with **diphtheria antitoxin** and 20 c.c. (5 drams) was administered subcutaneously. The bleeding ceased

promptly and did not recur. Broca (*Presse méd.*, No. 24, 1907).

The writer arrested threatening hemorrhages with **diphtheria antitoxin** in a hemophilic boy 4 years old. Success, however, was not complete until he had supplemented the diphtheria antitoxin with **fresh rabbit serum**. He holds that failures in the experience of others are due to the fact that the serum used was too old, or modified in some way. The injection of 10 or 20 c.c. (2½ to 5 drams) of serum should be repeated and pushed beyond the maximum generally accepted, and the fresher the serum the better the results. He injected 20 c.c. (5 drams) of antitoxin and 75 c.c. (2½ ounces) of rabbit serum in the course of eighteen days in the case reported. Gangani (*Gaz. degli Osped.*, June 15, 1909).

Case of a hemophilic mechanic who suffered from a laceration of a finger and in whom adrenalin, heat, pressure, and calcium chloride failed to control the bleeding. On the fourth day the writer injected 2000 units of **diphtheria antitoxin**, and on the next morning 2000 units more, with a stoppage of the hemorrhage within fourteen hours after the first dose. Hong (*Milwaukee Med. Jour.*, Feb., 1911).

In the treatment of **hemophilic hemorrhage** the **recumbent position** (except when the bleeding is at the nose) is of primary importance to reduce cardiac action. **Pressure** and **styptics** should then be used. **Morphine** hypodermically facilitates the action of the external remedies.

Diphtheria antitoxin has been found useful both as a local and subcutaneous styptic.

Of the agents so far used, however, **blood-serum**, first recommended by Weil, has been found to be the best. **Human blood-serum** is to be preferred to that of animals, owing to the fact that it does not tend to produce

anaphylaxis; 20 to 40 c.c. (5 to 10 drams) may be administered subcutaneously in the twenty-four hours. It may, in emergencies, be obtained from a willing relative or friend of the patient's. **Horse serum** or **rabbit serum** may also be used; Oliver has found the former effective when injected rectally. A piece of **fresh meat**, **squeezed over the wound** or applied to it, sometimes suffices to arrest the bleeding.

Transfusion sometimes becomes necessary, but it should be conducted with unusual care, owing to the morbid condition of the vascular walls. The best hemostatic is the **transfusion of entire blood**, of which but a small quantity will sometimes stop an otherwise uncontrollable hemorrhage, as long ago observed by Hayem. A few drops of **normal blood** from the nurse or surgeon sometimes suffices to arrest a bleeding wound in a hemophilic when applied to the wound. **Kneading of the tissues around the bleeding area** suffices to liberate enough thrombokinase to arrest the flow.

The writer has often obtained as high as 100 c.c. of blood from a single **rabbit**, and this furnishes about 50 c.c. of **serum**. The dose of this **serum** runs from 10 or 15 c.c. in a mild case or a very young infant to 30 or 50 c.c. in a more severe case or an older child. In severe cases this dose can be repeated at four- to six-hour intervals; in less severe cases it is given once a day for several days or until no new hemorrhages have appeared for about twenty-four hours; sometimes only one or two doses are necessary to control quite severe bleeding. W. P. Lucas (*Boston Med. and Surg. Jour.*, Nov. 18, 1909).

Analysis of the literature shows that the results of gelatin, calcium,

strontium, and ovarian and other organotherapy have been disappointing, although an occasional success has been realized. Far better results have been obtained with subcutaneous or intravenous injection of fresh animal **serum**, the method inaugurated by Weil, although Bienwald in 1897 reported the arrest of hemophilic hemorrhage by local application of normal human blood. In a personal case some blood was drawn from the child's grandmother and the traumatic wound in the left temple filled with the blood as a last resort. The foreign blood coagulated in the wound and the hemorrhage was arrested. Twenty cases have been published in which injection of serum arrested hemophilic hemorrhage more or less completely. To date only 2 cases have been reported in which no benefit was derived (Bonzani and Maclair). The effect of the serum does not last over a month. As a rule, 20 c.c. (5 drams) of serum is enough, but 40 c.c. (10 drams) may be injected without harm. No disturbances were observed in the writer's cases, not even when the injections were repeated. The subcutaneous route should be preferred unless the intravenous is urgently required. **Horse serum** seems preferable, and ordinary **diphtheria antitoxin** can be used, selecting the vials with the latest date, and applying the serum to the bleeding spot. K. Wirth (Centralbl. f. d. Grenzgeb. d. Med. u. Chir., Bd. xii, Nu. 7, 1909).

In a personal case the hemorrhage was promptly arrested by the injection of **serum** after failure of tamponing, adrenalin, and the thermocautery. The hemorrhage had persisted for two days, but stopped in a few minutes after a tampon dipped in fresh **diphtheria antitoxin** had been applied twice. Examination of the blood at the time and later showed normal coagulation; the hemorrhage had evidently been the result of some transient dyscrasia. E. W. Baum (Mitteil. a. d. Grenzgeb. d. Med. u. Chir., Bd. xx, Nu. 1, 1909).

Graphic tracings taken with the writer's coaguloviscosimeter sustain the assumption that the trouble in hemophilia is a lack of thrombokinase, and that hemophilic hemorrhage can be arrested by supplying this from without. All those who have anything to do with hemophiliacs should check hemorrhage at once by tamponing with fresh **animal blood or serum**.

The thrombokinase of the blood can be obtained at any time by simply soaking in water chopped and **ground fresh rabbit liver** or liver from any other animal. After filtering through an ordinary cloth, the turbid suspension thus obtained provides a physiological styptic which does not soon lose its efficacy; the extract, however, should be made fresh each time. In contact with the blood it constantly sets free new amounts of the ferment, which is thus applied nascent and displays most efficient action. Kottmann (Münch. med. Woch., Jan. 4, 1910).

In 1898 the writer treated "a whole family of bleeders—there were 8 of them—by the injection of **normal serum** in increasing doses, with marked success." The serum was prepared by the city bacteriologist of Newark, Dr. R. M. Connolly, and its use has been continued with unvaried success ever since. A. Frey (N. Y. Med. Jour., May 21, 1910).

The writer treated 3 newborn infants suffering with hemorrhage with **serum**. Two of these patients were apparently moribund when the serum was administered. The second case had not progressed so far as the other two, but was to be considered serious also, for previous to the injection the bowels had moved each hour for nine hours with large passages of dark, tarry, meconium-like material and bright red blood, and on the sixth day the baby weighed 24 ounces less than at birth, a portion of which large loss certainly could be attributed to the hemorrhage. Bigelow (Jour. Amer. Med. Assoc., July 30, 1910).

Research on 6 typical hemophilics. The practical lessons from this work are that the hemophilia may be constantly influenced by **repeated injection of fresh human blood-serum** for the purpose of thrombokinase enrichment by the intermediate link of antikinase production. Another way is by repeated withdrawal of small amounts of blood by puncture of a vein with a fine cannula, for the similar purpose of thrombokinase enrichment, by means of the physiological reaction that follows. Experience has shown that there is no danger of hemorrhage in a hemophilic if the vein is punctured with a fine cannula, permitting harmless withdrawal of blood and the consequent physiological reaction. Sahli (*Deut. Archiv f. klin. Med.*, Bd. xcix, Nu. 5-6, 1910).

In a girl with extreme hemophilia who was treated by **rabbit serum**, the weight increased 17 pounds in five months and it was hoped that she would outgrow the tendency, but the onset of menstruation brought excessive losses of blood and, although injection of 20 c.c. (5 drams) of rabbit serum had a strikingly favorable transient effect, the child succumbed to anemia. In a second case of hemophilia, in a boy of 9, the profuse hemorrhages were arrested at once by injection of 42 c.c. (10½ drams) of fresh rabbit serum in two weeks. In both cases there was intense oral fetor some days before the onset of the hemorrhages. The **kind of serum** used should be **changed** at the slightest indication of anaphylaxis. Trembur (*Mitteil. a. d. Grenzgeb. der Med. u. Chir.*, Bd. xxii, Nu. 1, 1910).

The injection of **normal human serum** never gives serum sickness nor causes anaphylaxis, and the writer further believes that it is actively bactericidal, and cites its use in a case of streptococcemia in which the injection of 50 c.c. (1½ ounces) of serum apparently brought about a subsidence of the temperature and a clearing of all bacteria from the blood. Welch (*Arch. of Pediatrics*, Sept., 1910).

Case of **blood transfusion** in hemophilia, the patient being only 2½ years old. The donor was a young man aged 19. The transfusion was continued for one hour and a half and was successful, checking all oozing. Goodman (*Annals of Surg.*, Oct., 1910).

In a case of obstinate hemorrhage from a wound in a hemophilic patient the bleeding was stopped at once by a few drops of the author's **own blood** applied to the cleansed bleeding surface. J. H. Sayer (*Jour. Amer. Med. Assoc.*, Jan. 13, 1912).

The use of **serum** injections, the injections of **defibrinated blood**, and **direct transfusion** seem to have yielded better results in the treatment of hemorrhage than any other measures. Moss and Gelien (*Bull. Johns Hopkins Hosp.*, July, 1911).

The coagulation time of the blood in hemophilic subjects is greatly shortened by the injection of fresh **serum** of any species. The sera of the ox and dog should be avoided because they are more apt to produce toxic symptoms. The local application of fresh serum to wounds in patients with delayed coagulation tends to act as a hemostatic. Regular antitoxic sera are less satisfactory than freshly drawn material. The action of serum in accelerating blood coagulation is apparently due to a substitution of active thrombin. Leschier (*N. Y. Med. Jour.*, Feb. 3, 1912).

Case of a hemophilic patient who was bleeding freely from an excoriation in the corner of the mouth after extraction of a tooth. He **squeezed** and **kneaded** the **tissues** around the tiny **wound** in the corner of the mouth, hoping thus to flood the spot with tissue juices which he hoped might contain the thrombokinase, the substance from which the coagulation-producing thrombin is formed and which seems to be lacking in hemophilic blood. The result was an instantaneous success. When the hemorrhage recurred later two or

three times it was arrested at once each time by squeezing the region with the fingers. Having **fresh goiter tissue material** at his disposal, the writer has been utilizing it for the purpose and commends it as the most effectual measure. Schloessmann (*Beiträge z. klin. Chir.*, Aug., 1912).

Minute clinical research in a case of hemophilia. Thrombokinase is certainly lacking in the blood, but it can be supplied from without by applying to the bleeding points **fresh blood-serum or tissue juice**. Gressot (*Zeit. f. klin. Med.*, Bd. lxxvi, Nu. 3-4, 1912).

The cutaneous or rectal injection of epinephrin, ergot, hamamelis, and calcium salts, etc., has been recommended in hemophilia, but the writer has not observed any striking results following the administration. In the case of a boy 5 years old who had been bleeding for nearly forty-eight hours from a small wound inside the lower lip caused by a fall on a fender, the injection of **horse serum by the rectum** very rapidly and permanently arrested the hemorrhage. In other cases, equally good results were obtained. Sir T. Oliver (*Pract.*, June, 1912).

Case of a woman of 50 who suffered from a hemorrhagic diathesis and excessive climacteric hemorrhages and extravasation of blood which was growing rapidly worse. The writer injected 40 c.c. (10 drams) of **defibrinated blood** from the patient's daughter. The hemorrhage stopped on the same day. Rubin (*Münch. med. Woch.*, Oct. 1, 1912).

Case in a boy aged 5 who, when seen six days after the injury, presented an almost hopeless case. The only thing left to be tried was **human serum**, and after carefully preparing the father's arm the median basilic vein was opened and about 8 ounces (240 c.c.) of blood received in a sterile bottle, which was placed in an ice-box for ten hours. Then 20 c.c. (4 drams) of the serum was injected subcutaneously into the child's buttock, and within twenty minutes a clot formed

on the child's tongue and the bleeding almost ceased. The clot became so large that it had to be removed in twelve hours, but there was no renewal of the bleeding. Traver (*Jour. Amer. Med. Assoc.*, Jan. 4, 1913).

In a case of war wound in a hemophilic described by the writers, the young man, his brother, his mother and her brother were all bleeders. The bleeding always stopped spontaneously about the twelfth day, regardless of the measures applied. Wounded in the hand, the hemorrhage kept up for the usual 12 days and then stopped, but the anemia was fulminating and extreme. Analyses showed there was no lack of fibrinogen or calcium salts. Neither horse serum nor beef serum accelerated coagulation, which demonstrates that these serums do not supply a lacking thrombozym but act as antigens, inducing an organic reaction. Fresh human serum shortened the interval before coagulation but this effect was still more marked with white corpuscles from normal human blood. When washed white corpuscles were added to the hemophilic blood, coagulation occurred rapidly. This seemed to show that the white corpuscles supplied the element which was lacking in the hemophilic blood. It is possible to obtain a **leukocyte clot** which might aid in arresting a hemophilic hemorrhage applied directly to the bleeding spot. Their method is to draw 5 or 10 c.c. ($1\frac{1}{4}$ to $2\frac{1}{2}$ drams) of venous blood into twice its volume of $\frac{1}{3}$ alcohol (*alcool au tiers*), then agitate. Centrifuge immediately and decant the hemolyzed fluid. The clot of leukocytes left can then be applied directly to the bleeding surface. Fiessinger and Montaz (*Lyon chir.*, July-Aug., 1917).

Gelatin was formerly recommended but it has failed in many instances, and is by no means as efficient as blood-serum. A **sterilized** preparation should alone be used. It may be used locally by the mouth or rectum.

Case in a girl of 13, coming from a family of bleeders, and herself subject to severe attacks of epistaxis, who menstruated for the first time in July, 1900, and who on December 6, 1900, had been flowing for two weeks. On December 8th she was delirious, and death was expected. As a last resort $\frac{1}{2}$ pint (250 c.c.) of 1 per cent. solution of **sterilized gelatin** was injected under the breast during the morning and again in the afternoon. The hemorrhage ceased, and the patient recovered. C. H. Hare (Boston Med. and Surg. Jour., July 18, 1901).

It was found that **gelatin** causes an increase in the viscosity, especially when given under the skin. Thus, in a case of hemoptysis the internal administration of 200 c.c. (6 $\frac{3}{4}$ ounces) causes the viscosity to rise in ten days by 0.6 in relation to the original value, while the injection of 40 c.c. (10 drams) of **sterile gelatin** solution caused it to rise in twenty-four hours by 1.4. In the author's opinion, gelatin given hypodermically is less exposed to fermentative process than when it is given by the mouth. The blood is also increased by the giving of gelatin, though the pulse rate is variable. Increase in the specific gravity of the blood is one of the factors in the hemostatic effect of gelatin. Cmunt (Med. Klinik, Aug. 25, 1912).

Adrenalin sometimes proves very useful. It should be applied in the form of the 1:1000 solution, or the **adrenalin chloride** salt may be applied to the bleeding surface directly.

Case of a male Hindoo Brahmin bleeder 32 years of age who presented the usual signs of partial exsanguination. The uvula was tremendously engorged $2\frac{1}{2}$ inches in length and bleeding freely. The engorged organ was seized with the forceps and cut off. A hypodermic injection wound was immediately controlled by the use of **adrenalin**, and the hemorrhage from the wound in the pharynx, which because of the

nature of the lesion was large, was also entirely stopped by adrenalin. The patient died six days later from intestinal hemorrhage. Ernest Francis (Brit. Med. Jour., May 28, 1904).

Peptones, preferably when rich in propeptone or albumose, such as that used in laboratories for culture media or **Witte's peptone** in 5 per cent. solution, has been praised by European writers and by some found superior to blood-serum. A clear solution is necessary, however; otherwise untoward general phenomena may be produced. Nolf recommends that **propeptone**, such as the above, be placed in fresh salt solution and boiled. When filtered and sterilized to 120° C. a perfectly clear and harmless solution is obtained, which will prove very efficient as an hemostatic.

In 9 cases hemophilic hemorrhage was arrested by injection of 10 c.c. (2 $\frac{1}{2}$ drams) of a 5 per cent. solution of **peptone (Witte)**. In some of the cases 2 injections were made as a prophylactic measure the first ten and the second two days before a major operation. In one case hematuria was arrested by one injection; the patient succumbed to hematemesis a year later. The patients were between 6 and 67 years old, and a single injection answered the purpose in nearly every case. The peptone seems to be more energetic and it is more easily sterilized than serum; heating to 120° C. (248° F.) for an hour does not alter its properties. It is injected as a 5 per cent. solution in a 0.5 per cent. solution of **sodium chloride**. There seems to be no danger of anaphylaxis. P. Nolf and A. Herri (Revue de méd., Feb., 1910).

Injections of **Witte's peptone** in the case of a boy 9 years old who presented all the clinical and hematological signs of hereditary hemophilia. Since the age of 4 months he had had subcutaneous hematomas, hematuria, hemorrhages from the

mucous membranes, and joint disturbances, besides showing a markedly lengthened coagulation time. Injections of fresh antidiphtheritic serum hastened coagulation, but had no influence on the general condition or hemorrhages. Nobécourt and Tixier (*Bull. méd.*, Oct. 26, 1910).

In a fatal case of melena neonatorum observed by the writer, the blood was found to be entirely lacking in thrombin or prothrombin, as shown by the fact that, left in contact with the tissues for twenty-four hours, it remained fluid, though tissue juices are known to neutralize rapidly any antithrombin and can clot "peptone blood," which is very rich in this substance. Whipple (*Arch. of Intern. Med.*, March, 1912).

The mother's blood is just as efficient for transfusion in these cases as that of any other donor. The mother should, indeed, be used as donor in every case, Cherry and Langrock having shown that it can be employed safely without hemolytic tests in newborn infants, whereas the father and other blood relatives require a careful test to prevent hemolysis and agglutination. This fact is of the greater importance because it is almost impossible to obtain enough blood from the infant for the necessary tests. Furthermore, valuable time is saved. R. Lewisohn (*Amer. Jour. of Obstet.*, June, 1918).

Actual cautery has been used with success to arrest hemophilic hemorrhage of the gums—usually a very stubborn form, owing to the proximity of the carotids.

In the treatment of joint disorders due to hemophilia they should be firmly **bandaged** when swollen and **kept at rest** until the effusion subsides. Unless this be done the ligaments become stretched and weakened, and the onset of osteoarthritis is hastened.

The treatment of the anemia fol-

lowing copious hemorrhages is the same as that of the ordinary form of the disease, **iron** being of special value. But with it should be given **pituitary, adrenal, or thyroid gland**, all of which tend to enhance the formation of coagulating ferment. Inhalations of **oxygen** at this time greatly hasten recovery. Calcium though theoretically indicated is useless.

In a boy of 9 years, with typical hemophilia, where coagulation time was about 2½ hours, the calcium content of his blood was normal. Under calcium lactate, calcium content increased, but his coagulation time lengthened to 4½ hours. When calcium feeding was omitted, the blood calcium returned to normal, and his coagulation time shortened to 2½ hours. This confirms the writer's clinical experience that calcium is useless. Laws and Cowie (*Amer. Jour. Dis. of Children*, Mar., 1917).

C. E. DE M. SAJOUS,
Philadelphia.

HEMOPTYSIS. See LUNGS, DISEASES OF.

HEMORRHAGE. See various conditions in which it occurs under **HEMORRHAGE** in **CLINICAL INDEX**.

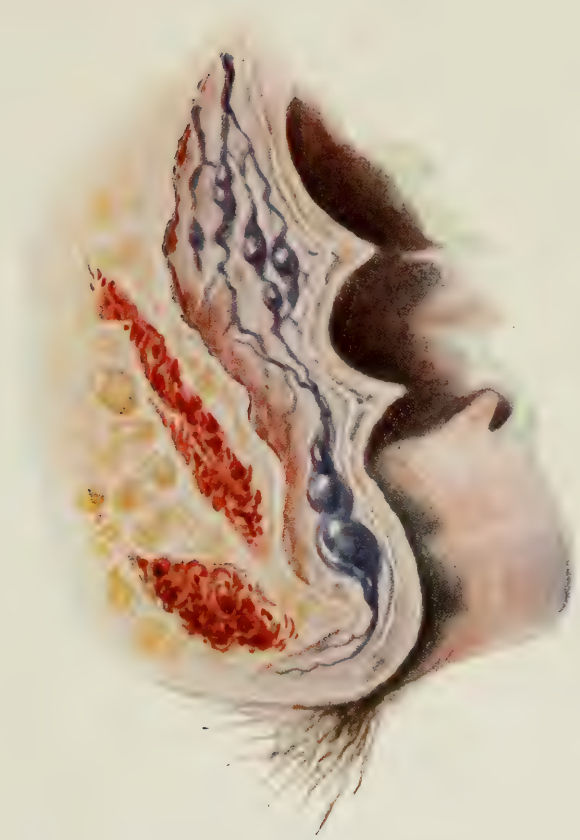
HEMORRHAGIC DISORDERS OF THE NEWBORN. See **NEWBORN, DISORDERS OF**, and **ADRENAL HEMORRHAGE**.

HEMORRHOIDS.—A hemorrhoid or pile is a vascular tumor of the rectum or anus, composed of varicose or thrombosed veins of the superior or the inferior hemorrhoidal systems. The middle hemorrhoidal veins, draining, as they do, the outer surface of the rectum and the upper surface of the levator ani muscles, do not enter into the formation of piles.

Clinically and morphologically,



Rectal mucosa and anal skin removed, showing the superior and inferior hemorrhoidal veins. Some hypertrophied anal papillæ are shown at the anorectal line. (*Collier F. Martin.*)



Section showing the superior and inferior hemorrhoidal veins and their anastomosis at the anorectal line. (*Collier F. Martin.*)

hemorrhoids may be differentiated as two main varieties, namely, external and internal. From an embryologic point of view, these two varieties must be considered as distinct, the anorectal line or dentate border being the true dividing line between them. *External hemorrhoids* are the result of pathological processes involving the inferior hemorrhoidal plexus of veins. *Internal hemorrhoids* result when the superior hemorrhoidal system is involved.

EMBRYOLOGY.—This is an important feature of the whole subject. The anal canal is developed from the outer layer of the blastoderm, or ectoderm. The infolding of the ectoderm at the site of the anus is called the proctodeum, or rudimentary anus. The rectum, on the other hand, is developed from the inner layer of the blastoderm, or entoderm. From the entoderm is developed the hind-gut, part of which goes to make up the rudimentary rectum. The rectum, at first, is separated from the proctodeum by two layers of mesodermic tissue, between the layers of which is developed the pleuroperitoneal cavity. As the rectum and the anal canal become more fully developed, these mesodermic layers are pressed together and become absorbed at the point of fusion. Where this absorption is normal, the anal canal becomes patulous, the line of union between the rectum and anus constituting the anorectal line or dentate border. As might be expected, the blood-supply of the rectum and anus are anatomically distinct, being separated by this line. Above this line the rectum is drained by the superior hemorrhoidal veins, which reach the portal circulation

by way of the inferior mesenteric vein. Below the dentate border, the anus is drained by the inferior hemorrhoidal veins, which run downward and outward, to the internal pudic veins. These veins, in turn, carry the blood to the inferior vena cava. While the blood-supplies of the anus and rectum are distinct, it must be remembered that there is a slight anastomosis between the superior and the inferior hemorrhoidal vascular systems. The middle hemorrhoidal vessels also anastomose both with the superior and the inferior hemorrhoidal arteries and veins. In cases of long-standing hemorrhoidal disease involving the two systems (the superior and inferior), the anastomosis becomes quite extensive, at times being so pronounced as to be easily demonstrable to the naked eye.

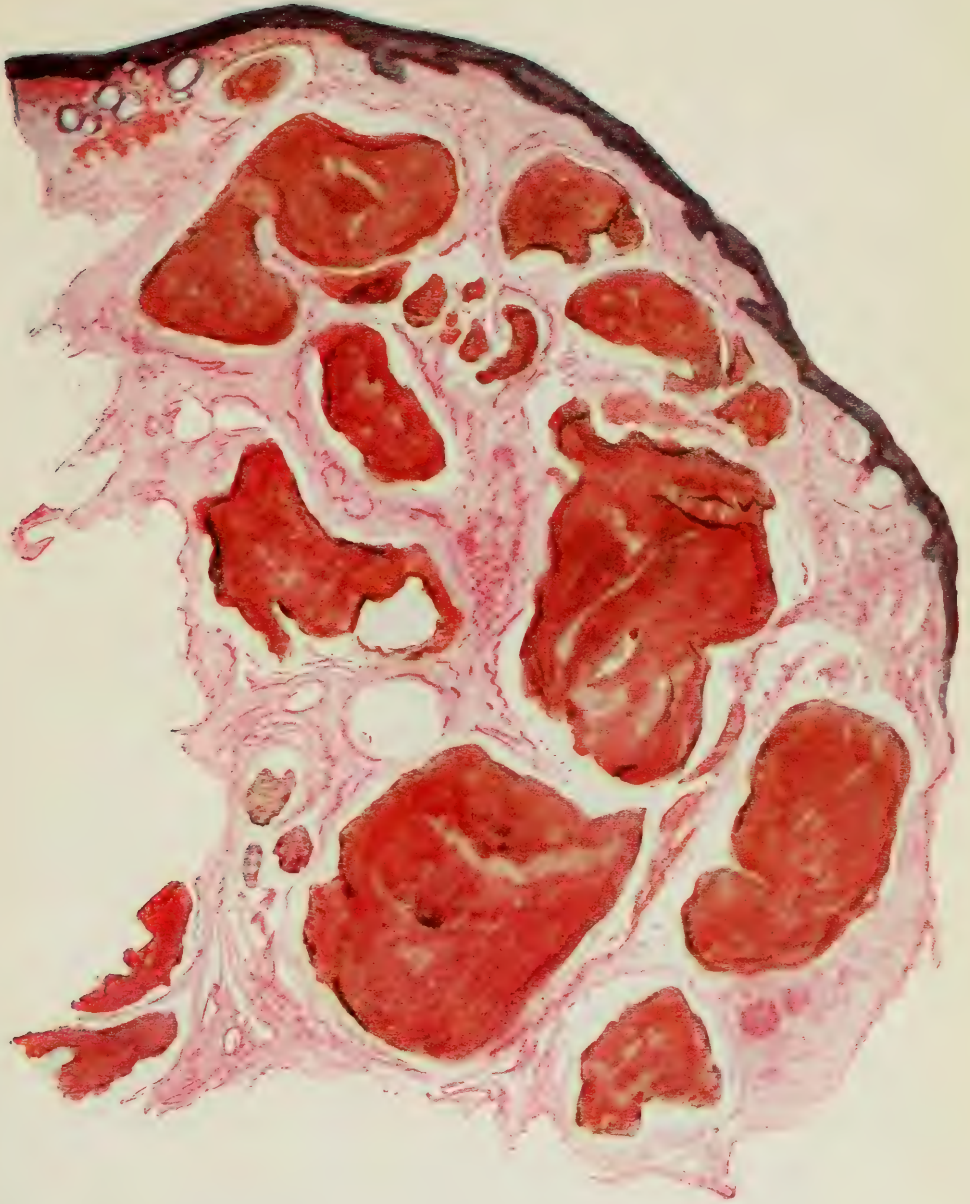
The anal canal, being developed from the ectoderm, is lined in its entirety by skin. This skin, because of its protected position, possesses certain peculiarities of cellular structure. This skin is called mucocutaneous. The term "modified skin" would be more appropriate and less confusing. The differentiation between external and internal piles becomes a simple matter when we take into account the anatomy of the parts. An external hemorrhoid may be recognized by the fact that it is *always* covered by skin, that all of the tissue involved lies below the anorectal line, and by the fact that the veins all belong to the inferior group of vessels. An internal pile is always covered by mucous membrane and limited at its lower border by this same anorectal line. The veins here involved belong to the

superior hemorrhoidal system and are connected with the portal circulation by the inferior mesenteric vein. It makes no difference how far a pile is prolapsed, it is always an internal hemorrhoid if covered by mucosa. Sometimes a large hemorrhoidal mass is seen which is covered by both mucosa and skin. This type of tumor has been called a combination or compound pile. A compound pile is composed of two distinct parts, an internal and an external pile, which lie in the same axis of the circumference of the bowel. When a compound hemorrhoid becomes strangulated and swollen, the two portions of the tumor will be seen to be separated by a deep, well-defined groove. This groove is formed by the anorectal line, and is rendered more apparent because it separates the superior from the inferior vessels, and the submucosa from the subcutaneous tissue of the anus. The submucosa of the lower rectum, being but loosely applied to the muscular wall of the rectum, allows the mucosa and the varicose veins to roll over the anorectal line and thus to become prolapsed.

Not only does the anorectal line form a barrier-reef between the distinctly different blood-supplies of the anus and rectum, but at this same line the nerve-supplies become differentiated. Below the anorectal line, the skin of the anus, the subcutaneous tissue, the external sphincter, and the levator ani muscles have a direct spinal innervation, derived from the third to the fifth sacral, and the coccygeal nerves. The rectum, beginning at the dentate border, or at the free borders of the semilunar valves of Morgagni, is supplied only by visceral branches, derived from the second

and third or the third and fourth sacral nerves. According to Piersol, while these fibers seemingly are derived directly from the spinal cord, they may be described more accurately as white rami communicantes, and reach their points of distribution only by way of the pelvic sympathetic plexuses. These nerve-fibers do not carry any of the specialized spinal sensations, such as touch, pain, heat, or cold. These visceral nerves, supplying, as they do, the involuntary musculature of the rectum, as well as the submucosa and the mucosa, do, however, carry pressure sensations. Their principal, and possibly only functions are motor and secretory. Necessarily, there must be afferent fibers, but the sensations are concerned only in carrying out the functions peculiar to the rectum itself, and are not of the protective type, such as we see resulting from irritation of the spinal nerves having a peripheral distribution. Because of this difference in the tegument, in the venous distribution, and in the innervation of the rectum and anus, external and internal hemorrhoids differ greatly in their etiology and in their subjective phenomena and objective characteristics.

The older investigators claimed that hemorrhoids were varices, but recently some have held that they are not mere dilatations of veins, but benign new growths—true angiomas. These differences of opinion led the writer to study the lower portion of the rectum at 200 consecutive autopsies, irrespective of whether symptoms referable to hemorrhoids had been present during life. In the fetus, in the newly born, and in children from 5 days to 8 years of age, he always found the vessels in the submucosa, especially at the lower



Multiple thrombosis in an external hemorrhoid. Microscopic section, showing: Skin covering normal. Marked inflammatory reaction in the subcutaneous tissue with evidences of new tissue formation, accounting for the residual hypertrophy, and formation of skin tags after the thrombi have been absorbed. (*Collier F. Martin.*)

edge of the internal sphincter and at the mucocutaneous junction, where hemorrhoids usually develop, more numerous than in other parts of the rectal wall. The older the individual, the thicker was the submucosa and the larger and more numerous were the vessels in it. Never was there any sign of new growth. Older individuals showed similar pictures, but when the submucosa was three or four times as thick as the normal, and the vessels were about ten times as wide as normal, he considered the condition a beginning hemorrhoid. He found that many persons had hemorrhoids from a microscopic point of view, although they may not have had any symptoms referable to them. The more marked the hemorrhoid, the thicker the submucosa, and the thinner the mucosa over it. When the hemorrhoids were large, he frequently found a round-cell infiltration in the mucosa and skin. As a result of these investigations, the writer concludes that hemorrhoids are not new growths, but merely dilated veins—varices. Ruediger-Rydygier, Jr. (*Deutsche Zeitschrift für Chirurgie*, Bd. xci, Nu. 5-6, 1908).

EXTERNAL HEMORRHOIDS.

External hemorrhoids present three varieties for consideration, namely, the *thrombotic pile*, the *cutaneous hypertrophy*, and the *intra-anal varicosity*.

The **thrombotic hemorrhoid** is an acute condition, coming on suddenly, accompanied by a sense of fullness and discomfort. Inspection reveals a swelling of the skin at the margin of the anus, ovoid in form, the blue color of the clotted blood showing through the skin, particularly when the skin is rendered tense by slightly stretching it over the tumor. At times the skin is acutely inflamed, being congested and discolored. Where the thrombus occurs in an old hypertrophied, cutaneous tag, or where the

thrombosis is multiple, the skin may be greatly swollen and edematous. While the occurrence of the single clot or thrombus is the rule, multiple thromboses are far from rare. When the thrombosis occurs within the anal canal the clot is more apt to be cylindrical in shape, so that the course of the vein involved can be clearly defined upon palpation. In this form there is apt to be much sphincter-spasm, and consequently more pain. These collections of blood, upon examination, frequently are found to be covered with a thin capsule, which consists of one or two of the coats of the ruptured vein. Where the vein-coat is completely ruptured, extravasation of the blood into the cellular subcutaneous tissue is apt to occur, giving the appearance of a circumscribed bruise or an irregularly shaped hematoma.

Thrombotic piles are essentially traumatic in origin. This condition is apt to occur at stool, the result of muscular effort, whether the bowels are loose or constipated. It occurs more frequently in the male sex, probably due to the relatively greater development of the anal sphincters and the accessory muscles of defecation. Great muscular effort, from lifting heavy weights, or, in fact, any form of exertion which may be associated with a sudden elevation of the intravenous blood-pressure, is an important causative factor. There seems to be a large class of individuals that, by reason of some inherent weakness of the vein-coats, is particularly prone to attacks of thrombosis. Patients in this class suffer from repeated attacks. Thrombosis of the inferior hemorrhoidal veins frequently is associated with an attack of acute

strangulation of internal piles, their presence adding much to the misery of the patient and somewhat complicating the case from an operative standpoint. The condition is a frequent complication following the traumatism of childbirth.

Perianal and anal thromboses pursue one of three courses: the acute inflammatory symptoms rapidly subside, accompanied by a gradual reduction in the size of the clot due to absorption, or else the clot may become infected, through the presence of pyogenic bacteria, and an abscess result, or, more rarely, the skin may become necrotic from pressure, and the clot be spontaneously extruded, accompanied by profuse hemorrhage. The rupture of one of these abscesses results in the formation of a small fistula. On the other hand, since the perianal lymphatics drain into the lymphatics of the inguinal region, the infection may spread in this direction, resulting in a bubo.

Even when absorption of the clot takes place, a slight thickening of the skin at the site of the pile is usually left, leading us to suspect that at least a low grade of local infection is the rule. When once a vein has been ruptured it never regains its tone, and clots are apt to recur, so that it is no unusual thing to obtain a history of repeated attacks occurring in the same place. After each succeeding attack the skin and the subcutaneous tissue become more and more hypertrophied from the deposit of inflammatory exudate, giving rise to the cutaneous tags or hypertrophic form of external piles.

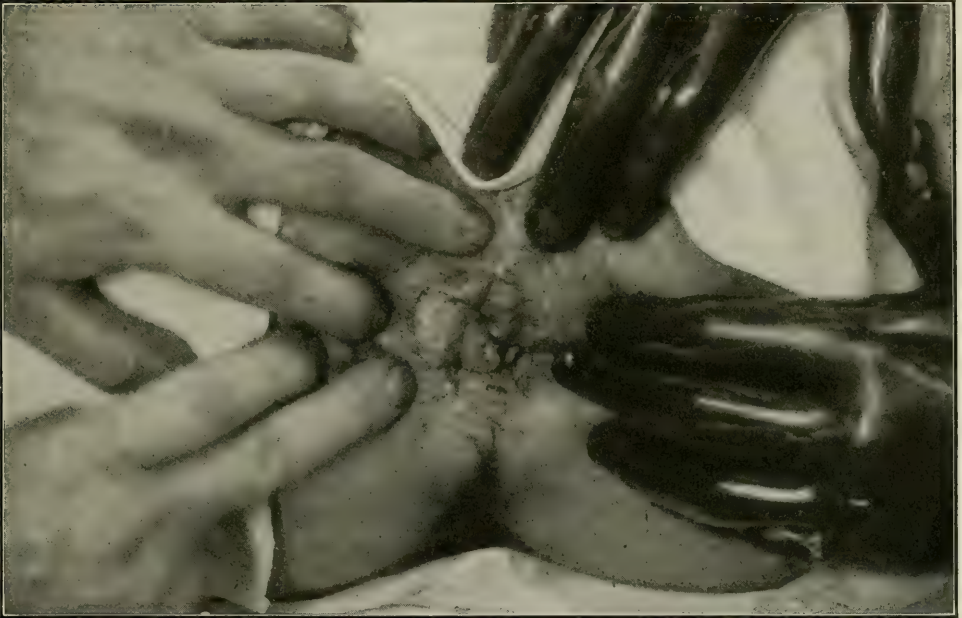
The diagnosis may be made from the history of a lump appearing suddenly under the skin at the margin

of the anus or within the anal canal, accompanied by more or less spasm of the sphincters and consequent pain. Parenthetically, it may be stated that the amount of pain experienced in anorectal disease, not due to suppuration, is directly proportionate to the amount of sphincter-spasm induced by the lesion. The patient feels as if a foreign body were present in the anal region. Constipation, if not already present and an etiologic factor in producing the condition, may result from irritation of the sphincters and from the fear of the pain occasioned by the act of defecation.

The **cutaneous tag**, or the **hypertrophic form of external hemorrhoids**, consists of a prolongation and overgrowth of the anal skin, produced by repeated attacks of inflammation. As mentioned before, they frequently follow the absorption of anal thrombi, but just as often they are caused by infection. Infection of the proctodeum, by blocking up the anal lymphatics, tends to leave an inflammatory deposit in and under the skin. Persons suffering from constipation associated with excessive straining at stool frequently develop these folds through a prolapsus of the anal skin, while almost constant congestion is productive of inflammatory changes. In stricture of the rectum, whether benign or malignant, a pronounced ring of hypertrophic skin-folds is usually present. This is associated with a patulous condition of the anal orifice, which, when present, is almost diagnostic of rectal obstruction. A patulous anus associated with a marked overgrowth of the anal skin is often seen in cases of spinal involvement where the sphincteric reflex is diminished, as observed in

cases suffering with locomotor ataxia. A careful examination of the nerve reflexes will clear up the diagnosis. Even in these cases, the thickening and overgrowth is probably due to inflammation and infection. In this type of cases we have the two factors of displacement or stretching of tissue and of inflammation at work.

This strangulation differs somewhat from that of prolapsed internal hemorrhoids, since the tumors are not caught in the grasp of the sphincters. The swelling of the skin is not caused by vascular congestion entirely, but is partially due to a lymphatic stasis resulting in extensive edema. Where there is extensive edema there is apt



Multiple anal thrombosis with slight edema. The little tumor protruding at the posterior margin of the anus is a hypertrophied anal papilla which has become polypoid in form. (Martin.)

Under ordinary conditions these skin tags give little trouble, other than the annoyance of their presence and in the added difficulty of keeping the parts clean. Patients often are blamed unjustly for being dirty in their habits, when, as a matter of fact, even with the greatest care they find it impossible to keep the perianal tissues clean, due to the extreme unevenness of the surface.

These folds are subject to attacks of acute inflammation, associated with a condition of partial strangulation.

to be associated a multiple thrombosis of the inferior hemorrhoidal veins; indeed, it is probable that, in these cases, the thrombosis antedates the production of the edema, and may be the causative factor thereof. Should an anal eczema or a pruritus be present, the condition will be greatly aggravated. Suppuration may occur, resulting in the formation of a marginal abscess, to be followed by a fistula.

We need be concerned with the symptoms of the above forms of piles

only when they are affected with some complication such as acute inflammation, strangulation, thrombosis, an associated anal eczema, or suppuration. At these times the patient is in exquisite misery, due to the inflammation of the parts and to the excessive spasm of the sphincters. Because of the rich spinal nerve supply of the anal tissues, the pain usually is much greater than is experienced in an attack of strangulated internal hemorrhoids unassociated with excessive anal inflammation. Constipation is the rule, and patients often render themselves more miserable by futile attempts at placing the swollen masses within the rectum, under the mistaken notion that they are prolapsed internal piles. The fact that the tumors are covered by skin, and not by mucous membrane, will instantly clear up the diagnosis.

The third variety of external hemorrhoids, the **intra-anal varicosity**, is not often mentioned as a distinct variety, being confounded with the internal variety. Normally, the inferior hemorrhoidal veins, just within the anus and before they pass over its lower margin, are of slightly larger caliber than they are after leaving the anus to join the internal pudic veins. In some cases the anal aperture appears normal, but when the patient is requested to strain down, these veins may swell up tremendously, producing quite a large tumor. It is not uncommon to find such a mass of varicosities situated just below a hypertrophied anal papilla. We have seen one of these hypertrophied papillæ, with an intra-anal pile below it, removed under the impression that it was an internal hemorrhoid. The fact that the tumor was covered by

modified skin should have shown the operator to which class it belonged. Under the influence of muscular effort, the tumors become globular or fusiform in shape, and the dark veins may be seen distinctly, shining through the skin, giving much the same appearance as would be seen in a case of intra-anal thrombosis, but without the production of a distinctly hard tumor. The distinction is an easy matter, for the tumor is compressible and painless, and when the patient ceases to strain, the tumor gradually disappears. Should a thrombus be present, it will be painful, firm to the touch, and does not tend to disappear when the muscular straining is stopped. In a compound pile it is this portion of the inferior hemorrhoidal veins which fuses into the internal pile above, although it must be remembered that these intra-anal piles may exist even where the other varieties are absent.

The etiology of this form is somewhat doubtful. From the frequency with which the condition is met in young people, where no other lesions are present, it is possible that the condition results from a congenital weakness of the veins, or that it is a form of diffuse angioma. In long-standing cases of internal and external hemorrhoids, these veins would naturally become varicose, due to the constant engorgement, stretching, and chronic inflammation present.

When not inflamed, this form of pile produces no symptoms other than the production, at the time of stool, of a tumor mass, which is mistaken for a prolapsed internal pile. Where a greatly hypertrophied anal papilla limits the upper border of an intra-anal pile, this may be caught by

the sphincters, producing a great deal of swelling and exquisite pain.

According to Sir Charles Ball, when internal hemorrhoids are prolapsed, there occurs a revolution of the lower zone of the anal canal, forming a well-defined ring about the protruded mass, frequently mistaken for external piles. Separating this ring from the hemorrhoids is an irregularly, but sharply defined, sulcus, formed by the anorectal line. It is this revolved anal border which produces the annoying swelling following operations on internal piles, often leading one to feel that too little tissue has been removed. This edema slowly subsides after operation, at times leaving little skin tags. These, if annoying to the patient, may be scissored off under local anesthesia.

TREATMENT OF EXTERNAL HEMORRHOIDS.—Logically, the treatment of external hemorrhoids consists in the removal of the offending tumor or tumors. We also endeavor to mitigate and allay the subjective symptoms, and, if possible, prevent a recurrence of the condition, by removing the cause, where known.

The following measures are efficient to reduce the suffering from hemorrhoids: After every defecation the patient uses only the finest tissue paper, and completes the cleaning with a piece of absorbent cotton, or a wad of soft cotton cloth, or a bunch of crumpled tissue paper thoroughly soaked with water. Soap also should occasionally be used. The tufts and the intervening grooves should be cleansed gently, but quite thoroughly. Next, a dusting powder, made up of **talcum** and about 10 per cent. of **boric acid**, is thickly dredged on the end of the finger, covered with dry cloth or tissue paper, and is then applied to the hemorrhoidal area. By this method the surfaces are

cleaned and putrefaction is avoided, softening of the tissue by retained moisture is prevented, itching is made impossible, and any slight abrasion is healed. After this treatment has been practised for a certain period the delicate mucous membrane becomes more and more like skin. Many a tormented patient can be rendered happy by this simple treatment. G. E. Barnes (N. Y. Med. Jour., Dec. 18, 1909).

The most effective and most satisfactory method, both to the patient and to the attending physician, is immediate operation. Such dread is there of surgical interference that often we are forced to accede to the wishes of the patient for palliative treatment. Again, on account of the presence of some other pathological condition, we may be compelled to forego operative interference.

The pain, in all cases of external piles, is the result of two factors: the local inflammation or infection of the parts, and the sphincteric spasm.

From clinical experience, we will have to admit that **diet**, *per se*, seems to play a very unimportant part either in the causation of external piles or in the relief of their unpleasant symptoms. Of course, foods which cause intestinal irritation, thereby producing frequent stools and increased muscular spasm, must be avoided. Food producing constipation, because of the excessive straining at stool, may be a factor in producing an attack of anal thrombosis or strangulation, and this would materially add to the discomfort of a patient during an attack of this distressing malady.

Traumatism, muscular exertion, exposure and physical exhaustion, and acute infection seem to play a far more important rôle than does diet.

It is not so much the quality of the food taken as it is the quantity. Overeating, resulting in general functional disturbances, such as increase in blood-pressure, constipation, diarrhea, and faulty metabolism, and in faulty secretion and excretion, should be discouraged. **Moderation in eating and drinking** should be the rule.

All varieties of *acute external piles* are greatly relieved by soothing and mild antiseptic washes and lotions, or by mild ointments. Our best efforts are directed toward the reduction of the local inflammatory condition and the relief of the spasm of the sphincters, where this exists. At night a **wet dressing** of a **saturated solution of boric acid**, or of the old, reliable **lead water and laudanum**, gives marked relief both from the local spasm and the inflammation of the swollen mass.

Where but little inflammation or hemorrhage occurs the following ointment is advisable:—

℞ *Cerati*,
Olei amygdalæ expressi,
Zinci oxidi,
 āā 3iiss (10 Gm.).
Balsami Peruviani gtt. iij.

Piece of this of size of hazelnut to be introduced high up through anus morning and evening, and especially before stool.

Where much hemorrhage, following may be used:—

℞ *Chrysarobini* . gr. xij (0.8 Gm.).
Iodoformi ... gr. v (0.3 Gm.).
Extracti belladonnæ fol. . gr x (0.6 Gm.).
Petrolati 3j (30 Gm.).

Hot water or **antipyrin** in powder or 2 per cent. solution is equally effective and less irritating.

Where the itching is intense:—

℞ *Albuminis* gr. xv (1 Gm.).
Camphoræ ... gr. xij (0.75 Gm.).
Adipis benzoinati 3j (30 Gm.).

Where much *moisture* and also *itching*, 10 per cent. **bismuth subsalicylate** powder useful. If much congestion is present:—

℞ *Bismuthi subsalicylatis*,
Zinci oxidi, āā gr. lxxv (5 Gm.).
Talci 3iij (90 Gm.).

In voluminous, readily prolapsing or bleeding hemorrhoids, an injection of **olive oil** should be taken every evening before retiring. Plicque (Bull. méd., June 1, 1912).

We have always felt that the use of belladonna to relax the sphincters was somewhat of a delusion and a snare, the drug having practically no effect upon the striated external sphincter. Where belladonna is used freely, either by suppository or as an ointment, very disagreeable consequences are apt to follow in persons susceptible to the influence of the stronger alkaloids.

During the day, there may be applied to the parts an **acetanilide ointment** composed of:—

℞ *Acetanilidi* 3ss (2 Gm.).
Ung. aquæ rosæ 3j (30 Gm.).

In addition to the antiseptic qualities of the acetanilide ointment, it has a decidedly sedative and anesthetic effect. The official **ointment of zinc oxide** or that of **calomel** is also very soothing.

The writer has had good results from the following ointment as a palliative in internal hemorrhoids:—

℞ *Solution of adrenalin* m̄x (0.6 c.c.).
Lanolin 3j (4 Gm.).

M. et ft. unguentum. Apply liberally to the anal canal once or twice daily.

For constipation in these cases the writer has advised **cascara** or **olive oil**, in combination with grape juice if desired. The temporary use of an injection of **cold water** after breakfast for a period not extending over two weeks is a good way to start the habit of moving the bowels at a regular time of the day. Bodkin (Amer. Med., May, 1911).

The writer found **injections** of 96 per cent. **alcohol** the most effective measure in 62 cases. His technique is as follows: The bowel is cleansed by catharsis and soap-suds enemas. Then, with the patient in the knee-elbow position and under local anesthesia, suction is applied to the venous knot. Next, the 96 per cent. solution of alcohol is injected deeply into the extra-anal knots, 2 cm. into the small knots and 5 cm. into those which were larger. After the injection the hemorrhoids are left outside or pushed high up into the rectum. Following this treatment the hemorrhoids become necrotic and slough off within a period varying from 6 to 14 days. The method is indicated in all cases of prolapsed hemorrhoids even though they may recede spontaneously. In cases of hemorrhage, rectal injections of 5 per cent. **calcium chloride** are given. In 64 per cent. of the cases healing occurred normally, but in 36 per cent. it was interrupted by recurrent hemorrhage, pain, and retention of urine. There was a recurrence in but 2 instances. Boas (Deut. med. Woch., Oct. 16, 1919).

If a **suppository** seems to be indicated, one composed of 3 minims (0.2 c.c.) of **ichthyol** and 20 grains (1.3 Gm.) of cocoa butter will be found efficient. It must be remembered that the use of a suppository is simply a convenient method of introducing an ointment into the rectum, and if we use too much medicament in proportion to the amount of adjuvant the ointment may be too strong, causing local irritation.

We often forget that, when we crowd a number of active drugs into a suppository, we not only obtain the therapeutic effects of the drugs, but we also get such an amount of local irritation as to neutralize our efforts toward relief of the symptoms. **Lycopodium** or **licorice powder**, particularly the former, when used by the druggist as a dusting powder for the suppositories, frequently is causative of the most acute suffering by inciting spasm of the sphincters. This is particularly true when there is associated an inflammatory condition of the crypts of Morgagni.

Suppositories of iodoform have been used with marked benefit, but, in addition to its penetrating odor, it, in common with many of the iodine preparations, is apt to produce, in susceptible individuals, a very annoying dermatitis. Following a suggestion of the late J. P. Tuttle, we have found great relief from the spasm of the sphincters to result from the injection of about a dram (4 c.c.) of a 10 per cent. **solution of colloidal silver** into the rectum twice daily. A suppository also helps to lubricate the rectum at stool, lessening the irritation.

Should the sphincter-spasm, pain, and edema of the anal tissues be extreme, immediate relief may be obtained by **divulsing the sphincters**, preferably under the influence of nitrous oxide gas. This procedure may be placed midway between the palliative and the operative treatment, as the relief afforded from the symptoms is marked, even should the offending hemorrhoids be left *in situ*. Frequently the patient will submit to this mild operation when he would absolutely reject even the slightest cutting procedure.

There is not the slightest reason why the piles should not be removed while the patient is under the anesthetic, other than the fact that frequently consent to this radical procedure cannot be obtained. Of course, where large amounts of tissue must be removed the patient would better be in his own home, or, preferably, confined for a short time in a hospital, where the operation can be carried out under proper surgical precautions. We are convinced that any rectal operation which may be followed by either hemorrhage or infection, or where a good illumination of the parts must be obtained in order to properly complete the same, should, if possible, be performed in a hospital, where the proper surgical technique can be followed.

The usual directions that *external thrombotic hemorrhoids* should be transfixied by a sharp bistoury, the clot turned out, and the cavity packed are certainly very unsatisfactory in the performance of this little operation. The following day the cavity will be found to be filled with another clot, which has to be evacuated, while, at the same time, the overlying skin will be found to be swollen and painful to the touch. A far better method is **removal** of external thrombotic hemorrhoids, by grasping the entire mass of swollen skin and the underlying clot with a hemostat or a volsellum forceps and then, with a pair of scissors curved on the flat, removing completely both the clot and the overhanging skin, taking care that the incision is carried far enough so that the thrombosed vein is cut off where it is perfectly healthy.

As a rule, the hemorrhage following the incision is slight. Bleeding

vessels may be caught and twisted, or, if deemed necessary, ligated. The wound, being perfectly flat, may be dressed with a simple pad of sterile gauze, held in place with a "T-bandage." Because of the retraction of the tissues, even an apparently extensive denudation is almost immediately converted into a linear wound, which will heal in a few days, requiring no attention other than surgical cleanliness.

Where the thrombus is large, the skin is so stretched by the clot and by the associated edema that, while we apparently have removed a large area of anal skin, in reality only a small portion has been excised.

Cutaneous tags or hypertrophic external hemorrhoids should be treated by **removal**. They may be scissored off level with the surrounding anal skin, care being taken to leave islands of skin between the denuded areas, so that there may be little or no contraction of the anal orifice. Occasionally, sutures are inserted to hold the skin edges in apposition, but this seems unnecessary if the denuded areas are made in such a manner as to form lines radiating from the center of the anal canal. The retraction of the anal tissues will convert seemingly broad wounds into linear ones, which will heal promptly.

Intra-anal varicosities requiring surgical interference should be carefully **dissected out**, and the **vessels ligated or twisted** to prevent hemorrhage. Should a *hypertrophic anal papilla* be present, this should be **removed** at the same time. A simple gauze pad should be placed over the anus. No packing should be inserted into the anal canal, as the packing keeps the parts on a tension, spread-

ing the wounds, and thus lengthening the process of repair.

While all forms of hemorrhoids can be operated upon under local anesthesia, general anesthesia is preferable. Local anesthesia will always have its field of usefulness in anorectal surgery, but it has certain limitations. Children and nervous patients are difficult to control. In addition, the extreme swelling of the tissues necessary to obtain anesthesia with the weak solutions now used, causes a very annoying distortion of the surgical landmarks, making accurate surgery difficult, if not impossible. The best cosmetic results are to be obtained only when the patient is perfectly under our control, and where the pathology of the part is not obscured by artificially induced edema.

INTERNAL HEMORRHOIDS.

Internal hemorrhoids, in all probability, begin as simple varices, although repeated attacks of inflammation may result in the production of local cavernous angiomata, thus forming true tumors. A so-called strawberry pile has been described, but this condition will be found to result from a dilatation of the capillaries of the rectal mucosa resembling a nevus in structure, but does not form a palpable tumor. Thrombosis of the superior hemorrhoidal vessels occurs, usually, as a complication of the ordinary varicosity, as the result of strangulation, and will be considered only as a complication and not as a distinct variety.

The etiology of internal hemorrhoids has been rendered so complicated by the multiplication of causative factors that some attempt to simplify the matter, by classifying

these factors into general groups, seems imperative.

The mechanism of the formation of internal hemorrhoids or rectal varices consists, first, in the establishment of a venous engorgement or stasis; secondly, in the elongation, stretching and dilatation of the venous loops, followed by the production of a tortuosity of these veins; and lastly, in a secondary inflammation or a low grade of infection, producing thickening of the vessel-wall, and inflammatory increase of the tissues of the submucosa and mucosa, producing a palpable tumor.

Venous engorgement or stasis of the superior hemorrhoidal veins begins in the most dependent portion of these vessels; in other words, in the little venous pools or blood-lakes situated in the submucosa just above the anorectal line. This stasis is purely mechanical, and is occasioned by any factor which offers resistance to the passage of the blood into the portal circulation. A direct tendency to engorgement is produced by the mere weight of the column of blood in these veins, which have no valves to distribute the back-pressure, and by the fact that the veins of the rectum have practically no support, lying loosely in the submucosa, not having muscular support, as do the veins in many other portions of the body.

It will be remembered that the superior hemorrhoidal veins leave the mucosa at a point about four and a half inches above the anal outlet, perforating the two muscular coats at this point, to be applied, more or less closely, to the outer surface of the longitudinal muscular coat of the rectum. At this point the veins pass through little buttonhole-like slits in

the muscular wall, and the theory, advanced by Verneuil, that these veins are here compressed, due to the contraction of the muscular coats, seems to possess some weight. The intravenous pressure may also be raised by pressure from without the rectum, as in the case of tumors, or a pregnant or misplaced uterus, or due to the presence of inflammatory or malignant tumors such as are seen in cases of stricture. Engorgement may also be caused by pressure from within the rectum, as from foreign bodies, or from the constant presence of feces. Probably there is nothing that raises the pressure of the blood in the lower portion of the veins of the rectum more than muscular action, such as is brought into play during the act of difficult defecation, or in lifting heavy weights.

Continued venous engorgement eventually results in stretching of the vein-coats, producing an elongation and tortuosity of these vessels. Just how much of a factor the weight of the unsupported blood-column plays in producing this elongation, is not clear, but certain it is that man alone, the only animal to persistently maintain the upright position, seems to be afflicted with rectal varicosities.

When many cases of internal hemorrhoids are examined, we are struck with the fact that the piles do not alone consist of simple varicosities, but that there is much added tissue, producing, oftentimes, a well-defined tumor. This adventitious tissue results from an inflammatory deposit not only in the coats of the veins themselves, but in a thickening and hypertrophy of the submucosa and of the overlying mucosa. When the pile is examined while protruded, it has a

dark-purple color, due to the distention of the varicosities with blood. When the hemorrhoid is seen through a speculum, in its flaccid state, it is dark red in color, and the small capillaries of the mucosa can be seen to be somewhat dilated. It seems highly probable that internal hemorrhoids become permanent tumors or angiomata only after persistent and numerous attacks of inflammation. The venous engorgement, followed by bacterial invasion, produces a localized phlebitis and periphlebitis.

The cardinal symptoms of internal hemorrhoids are bleeding, protrusion of the tumor mass at stool, a sense of fullness in the rectum, or the presence of a mucous discharge. Localized pain is present only when there is associated a cryptitis, a fissure, or when the piles are strangulated. Backache, pain over the sacrum or pubes, may be caused by other diseases of the rectum or of the urogenital tract which produce irritation of the pelvic sympathetic, and are not due to piles *per se*. The bleeding of internal hemorrhoids is usually venous in type, but may be of arterial origin. It usually occurs during or immediately after stool, as at such times the blood-vessels are extremely engorged. Attacks of bleeding are frequently ushered in with a history of some intestinal disturbance or infection, such as constipation, diarrhea, or even a bad cold. In other words, in many cases, the attacks of bleeding begin as the result of a mild proctitis, associated with more or less spasm of the sphincters. After a severe attack of bleeding the patient frequently seems far more comfortable, the local depletion of the tissues seeming to have a salutary effect on the condi-

tion. When the rectum is examined during one of these attacks, the mucosa will be found to be greatly congested, and at certain points on the surface of the piles will be noted small eroded areas. These erosions may be made to bleed by rubbing with a cotton swab. During the act of defecation, when the piles are protruded, the blood will be seen to ooze from the mucosa in quite a noticeable amount, trickling down and falling in large drops or even a steady stream into the toilet. At times, small rents or tears occur in the mucosa, and the blood is expelled in spurts. Theoretically, if the bleeding be of arterial origin, these spurts of blood should be synchronous with the pulse, while if it be of venous type, it should follow more nearly the rhythm of the respiration, and should be increased in quantity during the rhythmical contraction of the sphincter muscles. Accurate information upon this question is wanting. The localized muscular contractions of the sphincters, or spasms, seem to play quite an important part in producing rectal hemorrhage, for it has frequently been noted that the bleeding occurring at stool will cease, for from a few days to a period of months, following a divulsion of the sphincters. Excessive or repeated attacks of bleeding from the rectum may lead to a condition of profound anemia, which in a few instances has resulted fatally.

There seems to be a more or less prevalent belief that the protrusion of internal hemorrhoids takes place only when the sphincter muscles have become relaxed. This is supposed to occur when the pile has become large enough and the rectal mucosa sufficiently stretched to allow the mass to

be protruded through a flaccid sphincter. As a matter of fact, there is a very complicated and active mechanical process involved in the production of hemorrhoidal prolapse. The varicose veins constituting the vascular portion of the pile, in their course in the submucosa, are attached more closely to the mucous coat than to the muscular coat of the rectum. The tissue of the submucosa is arranged so loosely that, under perfectly normal conditions, the mucosa may be moved over the surface of the muscular coat for a distance of a half-inch or more. This condition is increased in pathological conditions. An internal hemorrhoid consists of a tumor composed of varicosities, thickened mucosa, and submucosa, which is more or less freely movable in the rectal ampulla. This tumor acts as a foreign body, both because of its pressure within the rectum and from the bacterial irritation, when active inflammation is present. The presence of a foreign body or of an acute inflammation in the rectum is accompanied by muscular effort on the part of the rectum to rid itself of the offending substance. Where the irritating stimulus is strong enough to produce subjective symptoms, we call the condition tenesmus. It is this muscular action, assisted by the friction of hard masses of feces passing through the rectum, that is concerned in the formation of polypoid growths from sessile tumors, and in the elongation of the mucosa covering an internal hemorrhoid. This tendency toward protrusion of piles is more pronounced when there is spasm of the sphincters than when these muscles are relaxed.

We frequently meet cases in which

the piles will protrude immediately they are replaced, and they can be made to remain above the sphincters only by allowing the patient to lie down for an hour or so after they have been replaced. After a **divulsion of the sphincters**, conditions are changed: the piles may protrude at



Thrombotic external and internal hemorrhoid (compound pile). (Martin.)

A, posterior surface of tumor, showing the veins filled with multiple thrombi. *B*, anterior surface. The deep transverse sulcus is formed by the anorectal line, separating the superior from the inferior hemorrhoidal vascular system. The modified skin of the anus ends abruptly at this line. Above, the tissue is covered by the normal rectal mucosa.

stool, but they tend to reduce themselves spontaneously after completion of the act, or else they can easily be replaced by the patient. The most noticeable fact is that they do not tend to prolapse as before, and the patient can immediately assume the erect posture without fearing that

the tumors will protrude. This condition of affairs is so marked that often the patient imagines that the piles have been removed and that he has been cured. This fact, and the fact mentioned above, that hemorrhage is temporarily arrested, has led to the erroneous belief that a divulsion of the sphincters will permanently cure hemorrhoids. While it is true that an acute attack, with its unpleasant and painful subjective symptoms, may be brought to an abrupt termination by this little operation, it must be remembered that the tumors, although reduced in size, remain, and, sooner or later, they will give rise to some subjective symptoms. Old chronic hemorrhoids, associated with a relaxed sphincter, usually are constantly protruded, and are associated with a more or less profuse discharge of rectal mucus. Where this condition is present, because of the relaxed condition of the sphincter muscles, patients rarely suffer from acute attacks of inflammation, with associated hemorrhoidal strangulation. The exposed mucous membrane keeps the perianal region and the underwear of the patient constantly moist and soiled.

Attacks of hemorrhoidal strangulation usually occur in patients having excessively irritable sphincters, particularly after the straining at stool caused by constipation, or by an overactive dose of a purgative used to relieve the constipation. Heavy lifting may also bring on an attack. Frequently these attacks follow exposure to cold or wet, or to an indiscretion in diet, or to excessive indulgence in alcohol. In these cases it is the associated constipation, or the efforts to relieve the constipation, that starts

the attack. The patient has a difficult or explosive stool, with sudden and excessive protrusion of the hemorrhoidal mass. The sphincters, under the influence of the sudden irritation, immediately contract about the protruded mass, thus preventing their spontaneous return into the rectum. The pressure of the sphincters, cutting off the return flow of blood from the superior hemorrhoidal veins, causes the mass to swell, effectually preventing the manual replacement of the piles. The veins in the strangulated tumor rapidly become thrombosed, the tissues greatly inflamed, and the patient suffers greatly.

TREATMENT OF INTERNAL HEMORRHOIDS.—The **palliative treatment** of internal hemorrhoids consists in the adoption, first, of such measures as will tend to prevent the further development of the tumors, and lessen the chances of future complications; secondly, of such measures as will relieve the subjective and objective symptoms already existing.

Constipation, particularly that type in which feces are retained for long periods of time in the rectal ampulla, is to be corrected where possible. Where this form of constipation is caused either by an overdeveloped or a spastic sphincter, marked relief may be obtained by a **divulsion of the sphincters**, either under nitrous oxide or local anesthesia. While **laxatives** may have to be administered, every effort should be made to create a regular habit on the part of the patient.

The anatomical structure of the anal canal is peculiarly non-resistant to mechanical and chemical influences. The zone intermediate between the skin and the rectal mucosa proper lacks the defenses of each, while scraps of stool are liable to lodge in

lengthwise folds and cause both mechanical and chemical injury. This is easily demonstrated by a small **cleansing enema** taken after defecation; it always brings scraps of stool away with it. A small tepid enema after defecation puts an end to hemorrhoidal disturbances that had tormented him for years, and his friends have reported similar experiences. Lenhossek (Deut. med. Woch., May 30, 1912).

The use of **solid carbon dioxide** gives good results in the treatment of small uncomplicated internal hemorrhoids. H. G. Anderson (Brit. Med. Jour., Jan. 20, 1912).

Moderation in eating and drinking is advisable, not so much because of any direct influence they may have in producing hemorrhoids, but because these are apt to produce more or less irregularity in the evacuations, resulting in frequent engorgement of the rectal veins.

Protrusion of the piles at stool and upon exertion being, as mentioned above, so often due to muscular action, little can be done to relieve it. Astringent injections and suppositories are apt to increase the tenesmus. The **injection of half an ounce (15 c.c.) of olive oil, at bedtime**, may lessen the tendency to protrusion when the bowels are moved in the morning. A **suppository** containing 3 minims (0.2 c.c.) of **ichthyol** and 20 grains (1.3 Gm.) of cacao butter, inserted at night, answers the same purpose. The patient should be encouraged to try to have the bowels moved regularly, once a day at least, and also to try to avoid undue muscular straining. The rectum may be emptied of any fecal accumulation by a **small enema**. This should consist of about half a pint or a pint (250 or 500 c.c.) of tepid water, injected

in the morning, at about the usual time for stool. If possible, the quantity should be decreased from day to day, rather than the reverse, and the temperature of the water may be reduced, until eventually the enema will consist of an ounce or two (30 to 60 c.c.) of cold water, at the temperature that it comes from the tap.

The same methods may be used to control *the bleeding* when it occurs. Where this is severe, the mucous membrane may be swabbed off with a **solution of silver nitrate**, containing about 10 grains (0.65 Gm.) to the ounce (30 c.c.). The excess of silver should be neutralized with sodium chloride solution. A little **olive oil** or an **ichthyol suppository** may be left in the rectum to lessen *the tenesmus*. If the bleeding persists, a **divulsion of the sphincters** should be performed. This will stop the bleeding temporarily, but the patient should be warned that it will probably return, and should be encouraged to have the hemorrhoids removed by more radical measures.

In 3 cases of bleeding hemorrhoids treatment by **thymus**, 30 to 120 grains (2 to 8 Gm.) of fresh dried gland, three or four times daily, caused great diminution or cessation of hemorrhages, and improved the state of the blood. Gwyer (N. Y. Med. Jour., Feb. 19, 1910).

When *strangulation* occurs, patients are usually in a more susceptible frame of mind, and if they will submit to an **operation**, by all means advise it. While operations at this time present a few more difficulties to the operator, it is often the only time that we can induce a patient to submit to this very necessary measure.

Should the patient refuse, as too often he will, he should be put to bed, and the **hemorrhoids replaced** if possible. This may best be accomplished by having the patient lie on the left side, with his buttocks slightly elevated, by placing a thick pillow under them, or he may be placed in the knee-chest posture. **Compresses, wrung out in very hot water**, should be applied to the parts, using **gentle pressure**. This pressure should be gradually increased. In a few minutes the swelling will be reduced and the sphincter muscles sufficiently relaxed so that, by gentle pressure, the prolapsed mass may be slipped through the sphincters.

If a finger be introduced into the rectum, gentle traction on the sphincters may relax them sufficiently to allow the piles to be replaced with ease. After the prolapse has been reduced, the anus should be greased with some **mild ointment**, and a firm **compress of gauze** should be applied, and held in place by a tightly adjusted "**T-bandage**." The patient should be **kept in bed** with the hips slightly elevated, until the acute inflammation has subsided. A **mild mixed diet** should be allowed, but milk, because of its constipating effect, should be avoided. The **bowels should be moved daily** either by enema or by a dose of **castor oil**. If the piles again protrude, they should be replaced immediately.

Where the prolapse cannot be replaced or retained, a **wet dressing** of a **saturated solution of boric acid** may be applied. A **hot-water bag** placed over the dressing, will serve to keep it warm and give the patient considerable comfort. The application of cold, in the form of an ice-bag, should

not be permitted, since severe sloughing of the parts is apt to result. Where the patient will submit to an anesthetic, but will permit of no radical operation, a **divulsion of the sphincters** will act like magic, relieving the pain and reducing the inflammation.

Prolapse of the hemorrhoidal nodules by continued pressure obtained by means of **Bier's suction cup** is recommended by the writer. Swelling of the nodules is thus produced, with edema of the anal ring; they become fixed in the anal opening, and the circulation is slowly shut off. The edema, after increasing during the first three or four days, then gradually subsides, and at the end of about eight days the nodules have usually diminished to one-half their former size, and in eight to fourteen days are no larger than a lentil.

The cup is applied over the prolapsed tumor and allowed to remain for half to one hour. The nodules become thrombosed in twenty-four hours. Hemorrhage may be checked by an **enema of calcium chloride**, 5 per cent. strength. The patient should be kept in bed for four or five days, and the bowels kept open by means of laxatives.

It is unconditionally the best among all bloodless methods. It is entirely free from dangers and complications, and it is applicable in cases in which operative treatment is out of the question. Another advantage is that the method can be applied in the home. The painfulness of the method varies; it was rarely necessary in his cases to resort to an injection of morphine; in a few cases a sedative suppository relieved the patients. All pains subsided with the edema; he does not combat the edema at first, as otherwise the nodules might slip back inside the anus. I. Boas (Münch. med. Woch., Jan. 30, 1912).

Boas's method of artificially inducing extra-anal incarceration of hemorrhoids is a very promising improve-

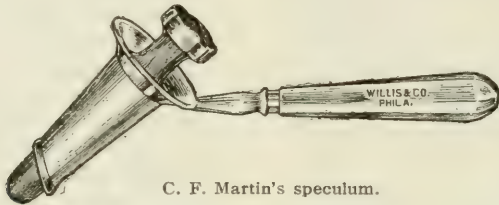
ment over operative measures. The writer has been applying this principle systematically in treatment for some years, urging patients to refrain from restoring the nodules to the bowel, and has found this an efficient and convenient method of shriveling up the nodules, some of his patients having been thus freed from disturbances for many years up to fifteen. The only measures he applies are opiates to relieve the tenesmus and local dressings of **aluminum acetate** to relieve the pains, which are considerable at first; after two days they become insignificant. Kofmann (Münch. med. Woch., April 16, 1912).

The writer tried **Boas's method** in 15 cases. It is a distinct progress in the treatment of hemorrhoids, especially for patients whose condition does not permit operative measures. For solitary nodules with a long pedicle it is preferable to all other methods of treatment. He advises it as a preliminary to any operation, as it may render the latter unnecessary. The patient should remain three or four days in bed and keep quiet for another week. By the end of the second week they are free to return to business. Maybaum (Archiv f. Gynäk., Bd. xcix, Nu. 2, 1913).

Operative Treatment.—Space not permitting a detailed account of all operations devised for the relief of internal hemorrhoids, only those will be selected which will serve to illustrate the classic types, with such modifications as are made necessary by modern clinical experience. The ideal operation for this condition does not exist. Each method must be selected according to the merits of the case, and according to the ability of the operator to properly perform the same. As a rule, every operator obtains the best average results by employing the method in which he is most skilled, departing from his favorite technique only when he sees

some special indication. For this reason, the relative merits of the various operations will not be discussed.

All of the operations so far devised can be placed into one of four classes: the injection treatment; the ligature method; the clamp and cautery operation; and the operation by excision of the pile-bearing area, originated by Whitehead. All of these procedures have been modified so many times that one would feel that any one of them must have had some objectionable features to have occasioned so many variations.



C. F. Martin's speculum.

The **injection treatment** may be employed in those cases where a more radical form of operation has been refused or where it is not desirable to confine the patient to bed, on account of poor health or old age, or even because he may be unable to give up his occupation even for the short time required by the more formal operations. In properly selected cases the results compare favorably with the ligature and the clamp and cautery operations. Carefully used, the dangers are no greater than with other methods, but it must be remembered that just as much care as to technique and asepsis must be used as in any operation about the rectum. External piles should never be treated by this method.

The **injection of carbolic acid** for the relief of internal hemorrhoids was

first employed by Mitchel, of Clinton, Ill., in 1871. Since then, many imitators, both regular and irregular, have devised innumerable modifications. The technique given below is that devised by my father, the late Dr. Robert W. Martin, in 1893. During the period 1877-93, he experimented with many other substances, such as hot water, the perchloride and persulphate of iron, ergot, hamamelis distillate, and alcohol, with frequent returns to carbolic acid. In 1893, the use of phénol sodique, or, more accurately, a 50 per cent. dilution of the original French phénol

Bobœuf, displaced all other forms of solution.

Briefly, the method may be described as follows: The sphincter muscles should first be divulsed under nitrous oxide anesthesia. This is done to prevent the unpleasant symptoms which will follow should a slough develop. Sloughing is also less likely to occur where the muscular irritability has thus been lessened. After three or four days an injection should be made into the largest pile. The tumors should not be protruded for this, but should be injected while in the rectal ampulla. This may best be done through a speculum, the small conical instrument used by him being the most convenient. The needle is inserted into the most prominent portion of the pile and from 5 to 10 minims (0.3 to 0.6 c.c.) of the solu-

tion is injected into the submucosa. The speculum should be removed before withdrawing the needle, thus preventing the backflow of solution which may be occasioned by the pressure of the speculum on the rectal wall. The solution used is a 50 per cent. dilution of phénol Bobœuf in water, but any other of the standard solutions may be tried.

The treatments are given at intervals of from three days to a week, depending upon the sensitiveness of the patient. After an injection a suppository containing 3 minims (0.2 c.c.) of **ichthyol**, is inserted. The patient should also be directed to insert one of these suppositories every night upon retiring.

Only one tumor is injected at a time and, should a slough develop, it should be cauterized with a strong solution or the pure stick of **nitrate of silver**. The acute inflammation is allowed to subside before continuing the treatment. The pain, even when a slough is present, is not severe, the patient simply complaining of a sense of fullness and a slight ache in the rectum.

The writer advises the injection into uncomplicated piles of a 5 to 10 per cent. solution of **carbolic acid**. Each of the hemorrhoids should be injected separately. The patient need only go to bed for the day and may go to work the next day. H. Schiemann (Med. Rec., Dec. 10, 1910).

Injection method used in about 450 cases with good results. Solution employed:—

R *Phenolis* 3j (4 Gm.).
Glycerini q. s.
Aquæ q. s. ad 3x (40 c.c.).

Phenol and water to be first mixed, then glycerin added drop by drop, stirring. About 50 per cent. of all cases could be safely treated and

cured by injections. **Clamp and cautery** should be preferred, however, where patient not opposed to operation and there is no contraindication. The cases especially suited for injection method are (1) the markedly anemic; (2) tuberculous subjects; (3) where organic disease contraindicates anesthesia, particularly if subjects highly nervous; (4) bleeders. Not over 10 minims of the 10 per cent. phenol solution to be used at one sitting. Humphreys (Amer. Jour. of Surg., March, 1913).

The purposes of the **clamp and cautery operation** are: 1, to remove actual piles, and, 2, to support relaxed pile bearing tissue and mucous membrane. Only just enough tissue should be removed to care for the morbid tissue, being sure that columns of mucosa and skin be left between the eschars, thus preventing any undue contraction of the rectal outlet. Unless the tissue included in the clamp is excessive it is not cut off but is destroyed by the careful application of the cautery. Care is taken that multiple strips of wet gauze be placed under the clamp to prevent undue radiation. Careful placing of the clamp, thorough cooking of the included tissue combined with the crushing produced by the clamp are depended upon to prevent hemorrhage. After all danger of secondary hemorrhage has passed, the insertion of a gloved finger overcomes the tendency to contraction. W. Oakley Hermance (Trans. Amer. Proct. Soc.; N. Y. Med. Jour., Mar. 16, 1918).

The **ligature operation**, for internal hemorrhoids, has many warm admirers, and inseparably connected with it are the names of the late Mr. Allingham, of London, and of Dr. Mathews, of this country. In this operation, after first gently divulsing the sphincter muscles, the piles are seized, one at a time, and dragged down outside of the anal orifice. A "U-shaped" incision is made through

the tegument, just below the base of the pile. This incision preferably should be made just below the ano-rectal line and above the "white line" of Hilton. The vertical portions of this incision are carried upward on either side of the pile. As the pile is lifted up off the muscular coat of the rectum, the dissection is carried upward under its base, thus forming a pedicle, composed of a narrow strip of mucosa and submucosa, carrying the varicose veins. A fine, strong linen ligature is either thrown around this pedicle, and tightly tied, or else the pedicle is transfixed with a needle carrying a double ligature, and the tissue ligated in two parts. The redundant tissue of the pile is now trimmed off, leaving just enough of a stump to prevent the ligature from slipping. After all of the tumors have been thus removed, a pad is placed over the anal region, this pad being held in place by a tight binder. The anus may first be dusted with some mild antiseptic powder or the pad may be moistened with a saturated solution of **boric acid**. Much of the postoperative comfort of the patient depends upon the separation of the hemorrhoid from the skin of the anus below, and in making the pedicle as thin as possible, so that too much tissue will not have to be cut through by the ligature.

If there should be much postoperative pain, this may be relieved by the administration of **morphine** hypodermically. A suppository of opium should not be inserted, as there may be no occasion for the use of any opiate. Should retention of urine occur, catheterization may be necessary. The bowels should be moved freely on the third or fourth day, by

the administration of sufficient laxative to overcome the extreme spasm of the sphincters which is usually present. The use of opium, other than to control pain, is unnecessary, for the inhibitory mechanism concerned in defecation is working overtime, a laxative being necessary before a movement of the bowels can be obtained. After the bowels have been opened, much swelling of the folds of skin of the anus nearly always follows. After a few days this will subside, often leaving small tags of skin at the anal margin. Should these folds produce any annoyance to the patient, they may be removed subsequently, under local anesthesia.

The results obtained with Ball's operation have not been so favorable as those that should follow the procedure. The postoperative pain is greater than after the usual ligature or the clamp and cautery method. The duration of the healing period is not shortened because of the sloughing of the ligature from either the skin-ring or the pedicle before union takes place, leaving the wounds to heal by granulation. There is a necessity for unusual watchfulness that all ligatures may be removed as they slough. Failing to secure primary union, skin-tabs frequently remain for subsequent removal. No time is saved by this modification of the ligature operation. There is danger of secondary hemorrhage from an early tearing off of the pedicle. Combs (Proctologist, Sept., 1909).

After a trial of Sir Charles **Ball's operation**, the writer's conclusions are as follows: That, as a modification of the old ligature operation, it is better than the latter, and at the same time is far superior to the clamp and cautery operation, in that it takes care of and avoids the recurrence of that revoluted anal skin-ring, which generally becomes mark-

edly edematous immediately after these operations, leaving behind skin tags after the swelling subsided. In every instance in which the essentials of Ball's technique had been followed out carefully the writer's results were exceedingly satisfactory. A. J. Zobel (N. Y. Med. Jour., Sept. 27, 1913).

The clamp and cautery operation, popularized by Henry Smith, in 1861, has had many ardent followers, both in our country and abroad. In the hands of the average operator, this method has produced radical results, and has been followed by few unpleasant sequelæ. After divulsion of the sphincters, the hemorrhoids should be drawn down, and the same division, between the skin and mucous membrane, should be made as in the ligature operation, and the clamp should be applied to the pedicle, in the long axis of the bowel. The projecting pile should then be trimmed off with the scissors, leaving sufficient tissue to be cooked by the cautery. The **Paquelin cautery**, the **electro-cautery**, or even an ordinary soldering iron may be employed at this stage of the operation. The stump, grasped in the clamp, should be cooked thoroughly, with the cautery at a dull red heat. A white heat produces excessive charring of the tissues, which are apt to separate prematurely, causing alarming hemorrhage. A piece of wet gauze, twisted about the pedicle of the pile, under the clamp, will prevent any undue radiation of heat, resulting in scorching of the anal skin, or in the destruction of the tissue below the clamp.

Stricture following this operation is due not so much to the placing of the clamp across the long axis of the

gut as to the excessive cooking of the tissues beneath the clamp, causing wide and deep sloughs. If too much mucous membrane is included in the grasp of the clamp, and if four or five such burns are made, almost the entire lower inch of the rectum may be denuded before we are aware of the fact. Care should be taken not to scorch or burn the anal skin, as the resulting condition causes the patient much unnecessary pain. Properly performed, the operation is followed by little pain, and retention of urine is infrequent.

After operation the anal region is covered with a pad of gauze saturated either with a **solution of bicarbonate of soda** or of **boric acid**. These pads should be changed as often as they become soiled. The bowels should be opened on the third or fourth day following operation. After the fifth day, the attending physician should insert the lubricated forefinger into the rectal ampulla, to see that the anal canal is patulous, as a too extensive denudation may result in some adhesion of the raw surfaces, producing narrowing of the anal orifice.

At the time of operation, any hypertrophied skin folds should be removed with the scissors before the sphincters are divulsed, for after the divulsion the protrusion of the internal hemorrhoids is followed by the formation of a revolved fold of the skin lining the anal canal, which is often mistaken for external piles. The too free removal of this skin fold is apt to be followed by some stenosis of the anal canal. Following operation, particularly after the first bowel movement, considerable swelling of the anal skin occurs, which, on subsiding, leaves more or less irregularity of the anal

margin. These folds may be removed subsequently under local anesthesia.

The **excision** of internal hemorrhoids, originated by Whitehead, and slightly modified by Tuttle, has as its object the removal of the entire pile-bearing area of the rectum. The technique is based upon the two important facts that internal hemorrhoids involve only the lower inch of the rectum, and that the veins of the hemorrhoidal plexus are more firmly attached to the mucosa than they are to the muscular coat of the bowel. Tuttle's operation, for practical purposes, may be divided into three stages: In the first stage, after the sphincters have been divulsed, a small incision is made posteriorly, just between the skin and mucosa at the anorectal line. A pair of blunt scissors, curved on the flat, is closed and pushed up under the mucosa. Using the closed scissors as a blunt dissector, the rectal mucous membrane is separated from the muscular wall, as far as the upper limit of the piles. The mucosa is stripped off, just as one would peel an orange, out of the skin, the veins remaining attached to it. Anteriorly, in the median line, the mucosa is slightly more adherent, but, with care, can be loosened. In the second stage, after the mucosa has been detached, the scissors are withdrawn, and one blade introduced into the incision. The tissue is carefully divided, at the anorectal line, completely around the anus. The blood-vessels at this point are usually small and little bleeding occurs. In the last stage of the operation, the entire cuff of loosened mucous membrane, containing the pathologic veins, is pulled down outside of the anal canal. This cuff is split longitudinally, in the

posterior median line, up to the superior level of the hemorrhoids. A retaining-suture, of heavy catgut, is placed at the upper angle of this incision, fastening the mucosa to the skin below. From this point the mucous membrane is divided, the incision being carried completely around the bowel. Only a short cut is made at a time, the mucosa being sutured to the skin as the operation progresses. After the line of suture has been carried half way around the bowel, to the anterior commissure, a new suture is started at the posterior commissure, but carried in the opposite direction, until it meets the first suture, anteriorly. This is done to obtain a more uniform apposition of the line of suture. This suture is simply a running stitch. If at any point in the sewing, a vessel bleeds too freely, the suture can simply be carried back around the bleeding point, thus effectually ligating the vessel. If care be taken not to make too long an incision in the mucosa at one time, little trouble will be experienced with hemorrhage.

Whitehead's operation is best adapted to voluminous hemorrhoids, internal or external, when they occupy the periphery of the anus, especially if the patient's general health be much affected by them. It is especially useful in combined type of hemorrhoids, internal and external. The operation has been undeservedly condemned because of atony of the sphincter, which will only be temporary if the preoperative and postoperative rules have been followed. It suppresses the entirety of the diseased mucosa and cannot be followed by recurrences and the patients remain cured. C. Courcières (*Arch. gén. de chir.*, March, 1908).

After twenty years' experience with various operations for the cure

of hemorrhoids, the writer recommends **Whitehead's operation** as at once the most effective, the least painful, and the safest, but it is necessary that certain precautions should be taken beforehand, and that the technique should be carried out very carefully. The intestinal tract should be previously cleared as much as possible. Bishop (Brit. Med. Jour., Oct. 30, 1909).

The **Whitehead operation** should not be employed in all cases of hemorrhoids. It is indicated only (1) when there is a general hemorrhoidal condition involving the whole circumference of the anal canal, and especially if there is a good deal of prolapse, and also in cases in which there is extensive thrombosis; (2) in cases in which, though the piles may not be large, the anal valves are enlarged, and little blind, submucous pockets may be found running for a varying length upward or downward toward the anus. Anderson (Brit. Med. Jour., Oct. 30, 1909).

The writer describes an operation suitable in the same cases as Whitehead's operation, but almost bloodless, and less liable to complications. After dilatation, a silk suture is passed at junction of skin and mucosa in the midperineal line, and one on either side of the anus. When traction is made on all 3 the extruded mucosa is triangular. The sides of the triangle are successively clamped and dealt with. Two Hagedorn needles are threaded at either end of a silk suture. The first stitch is placed at the apex of the triangle and tied at the center of the thread. The clamp being removed, the 2 needles are passed through from opposite sides at the same points (cobbler's stitch). Each stitch is pulled taut but not tied. The suture is continued at $\frac{1}{4}$ inch intervals until the lower end of this side of the triangle is reached, where it is tied. The redundant tissue is clipped away $\frac{1}{16}$ inch from the line of suture, and the narrow ridge thus left lightly touched with the thermocautery. The other

2 sides of the triangle are similarly treated. In 21 cases this operation gave satisfactory results. F. M. Bell (Brit. Med. Jour., Mar. 18, 1916).

After the operation is completed, a rubber-covered plug is inserted into the anal canal, its purpose being to obliterate the dead space left below the mucosa and to prevent oozing from the wound. These pressure-plugs are made with a drainage-tube passing through them, to allow the escape of flatus. A firm pad is placed over the anal region. This pad is perforated to allow the tube to project, and is held in place by a tight "T-bandage." The plug may be removed and the bowels evacuated on the fourth or fifth day following operation.

The writer's experience with the **excision operation** extends over nearly twenty years, during which time a very large number of patients have been operated upon, with healing by primary union, and, as far as the author knows, complete and permanent cure, and without immediate or remote complication, secondary hemorrhage, loss of sphincter control, infection, or stricture. The operation consists in removing the circular cuff of mucous membrane, which should contain the greater bulk of the dilated vessels, without exposing the underlying sphincter muscle. The lower margin of the cuff must not extend closer than $\frac{1}{32}$ inch above the line of mucocutaneous junction at the anus. In removing the cuff the dilated vessels are to be cut through with scissors and never dissected out from pockets in the muscle. The operation is completed by suturing the rectal mucosa to the narrow edge of mucosa left at the anus. No dressing at all is employed. The bowels are opened by **calomel** on the third day and the patient is allowed to sit up on the fourth. No enemata are used. The

operation requires from twenty to thirty minutes and is always done after the acute stage of the disease has passed as the result of rest in bed, if that is needed. Beyea (N. Y. Med. Jour., from Penna. Med. Jour., Aug., 1912).

If primary union takes place, the results are ideal, but should the suture line become infected, or pull apart, more or less stenosis of the parts may result. Care must be exercised not to remove any of the anal skin, for if too much is taken off, the anus will be lined with mucosa. This will produce a condition in which there is constant moisture of the anus, from the escape of rectal mucus. This is extremely annoying to the patient, and at times may necessitate another operation for its relief.

Some disturbances of the anal sensations and a few cases of fecal incontinence have been reported following this operation. In all probability, the too free removal of the anal skin will account for the sensory disturbances. The fecal incontinence will probably be found to depend upon some fault in the innervation of the parts, such as is seen in cases suffering with locomotor ataxia and other forms of spinal sclerosis.

Of 185 cases in which the writer resorted to **Whitehead's operation**, 31 have been operated on less than five years, 59 from five to ten years, 58 from ten to fifteen years, and 37 from fifteen to twenty-two years. The results were perfect in every respect in 134 cases, a percentage of 72.4. The most frequent untoward result was disturbance of the sphincter action, leading either to weakness of or imperfect control of the bowel. In many cases the patient experienced inconvenience in this respect only when from medication or indiscretion in diet, which then caused

an attack of diarrhea. In 37 cases the muscular control was more or less impaired, but in 1 only was there actual paralysis of the sphincter. This patient developed hemiplegia five years after his operation; hence the Whitehead operation was probably not alone responsible for the paralysis of the sphincter. Of these 37 patients 8 complained of pruritus or moisture following the operation, but in most of them this was temporary. Others suffered for five or six months from sensory disturbances. In 16 the itching and moisture are still complained of by the patient. In many instances the annoyance was said to be "slight." In 5 there is a certain degree of stricture.

In 14 a recurrence in some measure had taken place; one had had a perfect result for nineteen years and then developed a thrombotic external pile. Another had 2 small skin tags remaining from the operation. A third has a small external pile. In another there is still "some bleeding"; 4 others have what they describe as a "little return" of the hemorrhoids. Stone (Annals of Surg., Nov., 1913).

Hemorrhoids should be operated upon under combined local anesthesia and morphine and scopolamine narcosis. The writer points out the great difficulty of securing any satisfactory anesthesia in the region of the rectum by nerve blocking. His technique consists of the preparation of the patient by thorough emptying of the bowels with a laxative the day before the operation; giving only light, easily digestible diet; then shaving the perineal region and applying a sterile dressing the night before. Three hours before operation an enema is given, and 1 hour before, a cup of soup or milk, at which time 15 milligrams ($\frac{1}{4}$ grain) of **morphine**, 0.6 milligram ($\frac{1}{100}$ grain) **hyoscyne**, and 0.4 milligram ($\frac{1}{50}$ grain) of **atropine** are injected. The same precautions for the exclusion of external stimuli should be observed as in the case of "painless childbirth." The

skin in the median raphe, $1\frac{1}{2}$ inches behind the anal margin, is touched with pure phenol and after a few minutes' infiltration, anesthesia with warmed $\frac{1}{2}$ per cent. **novocain** solution is begun at this point and carried forward to include both sides of the anus. The process is then repeated, beginning at the anterior commissure. The mucosa of the anus is next anesthetized by the insertion of a wad of cotton soaked in 10 per cent. **quinine** and **urea hydrochloride**. After 10 minutes the left index finger is passed into the rectum, hooked over the anal muscles and the anus put on the stretch. A little over 1 c.c. (16 minims) of the novocain solution is then injected into the anal muscle on each side and in front and behind, and 1 syringe-ful is injected immediately in front of the coccyx. After 5 minutes the anesthesia is complete, the sphincter is well relaxed and can be dilated to its fullest extent without danger of injury. With the piles thus exposed, each is infiltrated with $\frac{1}{2}$ per cent. solution of quinine and urea hydrochloride and the mucosa for $\frac{1}{2}$ inch above is included. After 5 to 10 minutes the hemorrhoids can be dissected out painlessly by lateral incisions at their bases, made in the long axis of the rectum.

As the next step the hemorrhoid is freed to its pedicle, this is ligated and the end of the ligature, threaded on a needle, is passed through its base and tied over the top of the stump after cutting off the pile close to the base. The incision is closed with a running catgut suture. C. J. Drueck (Chicago Med. Recorder, Dec., 1917).

After any operation upon the rectum, should *infection* or *hemorrhage* occur, the patient should be anesthetized immediately, and the condition appropriately dealt with. Packing of the rectum for hemorrhage, except as an emergency, is a blind operation at the best, and is very painful to the patient. It is better to anesthetize

the patient, and search for and tie the bleeding vessels.

Local anesthesia conduces to a much more rapid recovery than does general anesthesia, although it cannot be employed in every instance. Pennington (Chicago Med. Recorder, Feb. 15, 1907).

The simplest operative procedure for hemorrhoids consists in excising the masses by oval incisions, the axes of the incisions being parallel with the sphincter muscle. The muscle need not be injured. The incisions are carefully closed by many interrupted catgut sutures. A dressing of heavy **zinc oxide ointment** is applied. Van Hook (Ill. Med. Jour., Feb., 1913).

Injection of **quinine** and **urea hydrochloride solution** is deemed safe and efficient in selected cases. In 2 years 127 cases of uncomplicated internal hemorrhoids were treated with but 1 failure. The quinine and urea in 5 to 20 per cent. solutions produces starvation and atrophy of the hemorrhoids. E. H. Terrell (Trans. Amer. Proct. Soc., June, 1916).

COLLIER F. MARTIN,
Philadelphia.

HENBANE. See **HYOSCYAMUS**.

HENPUE. See **GOUNDOU**.

HEREDITARY ATAXIA. See **SPINAL CORD, DISEASES OF**.

HERNIA.—DEFINITION.—The term hernia is used to denote the protrusion of one or more of the abdominal viscera, and is synonymous with the ordinary term "rupture."

VARIETIES.—If the protrusion occurs through openings in the abdominal wall which, normally patent in fetal life, through some defect in development have failed to close at birth, the hernia is said to be *congenital*. The protrusion usually occurs at

points in the abdominal wall by nature weaker than elsewhere, viz., in the femoral region, in the inguinal canal, and at the umbilicus. If the protrusion takes place through an opening not present at birth or in a sac that has developed since birth it is called an *acquired* hernia. Within the last two decades, with a greatly increased knowledge of hernia due to the very large number of operations for radical cure, we have learned that nearly all hernias are really congenital, that is, the sac or funicular process of peritoneum is of prenatal origin. The experimented studies on the cadaver by Murray, of Liverpool, still further confirm this belief.

In addition to the varieties above mentioned there may occur ventral hernia following abdominal incisions or accidental wounds. This variety is frequently known as traumatic hernia. A hernia takes its name from the site of the opening through which it protrudes. The common forms are: *inguinal*, *femoral*, *umbilical*, and *ventral*. The rare forms are: *diaphragmatic*, *lumbar*, *obturator*, *ischiatric*, *puddendal*, *perineal*, *properitoneal*, and *retroperitoneal*.

Distinction is made by some surgeons between *external* hernia, including all the varieties above mentioned, and *internal* hernia, by which latter is meant the protrusion of a viscus through some anomalous pouch in the peritoneum.

From 1891 to 1918 there were treated by radical operation at the Hospital for Ruptured and Crippled, New York City, 8589 patients. The mortality statistics have changed but little. The first ten years it was .22 per cent., while during the third decade it was .15 per cent. Coley and Huguot (*Annals of Surg.*, Sept., 1918).

SURGICAL ANATOMY.—A hernia consists of a sac, the coverings of the sac, and contents. The sac is always a prolongation of the parietal peritoneum; it varies in size and shape according to the stage of the hernia. At first it is merely a pouting or bulging into the hernial orifice, narrow at the end and wide at the base. As the hernia extends and emerges from the orifice, the sac is elongated, and from the pressure of the contents the lower portion becomes globular or pyriform in shape. The narrowest part of the sac is called the *neck*, and the external, or distal, portion is called the *fundus*. A sac formed in this way—namely, by a gradual pushing forward of the parietal peritoneum—is said to be acquired, while a congenital sac is preformed, the protrusion occurring in the open tunica vaginalis or through the patent navel. A congenital hernia, while it may appear late in life, is dependent upon conditions which existed at birth.

Adhesions may occur between the sac and its contents. The sac may become greatly thickened and opaque,—usually owing to the irritation of an ill-fitting truss,—and may undergo calcareous or malignant degeneration. Certain hernias are said to have no sac,—as, for instance, hernia of the bladder, sigmoid flexure, or cecum. This is not entirely true; a sac exists, but the peritoneum does not completely surround the viscus.

[Two important papers on extraocular hernia were published by Walton and Ransohoff in the *Annals of Surgery*, 1912. WILLIAM B. COLEY].

The coverings of the sac are made up of the different layers of tissue outside of it. These, of course, vary

according to the site of the hernia. An accurate knowledge of these layers is very necessary to the surgeon, owing to the great importance given to modern methods for radical cure.

Every viscus, except the pancreas, has been found in some variety of hernia. The contents are usually made up either of intestine or omentum, or both. If the hernia is reducible, the bowel and omentum present a normal appearance; but if irreducible, and the hernia of long duration, numerous pathological changes are likely to occur. The omentum becomes thickened and adherent to the sac, usually at the neck, or to the bowel, if that be present. A small amount of serous exudate is not infrequently present in an irreducible hernia.

If the hernia contains omentum alone, it is called an *epiplocele*; if bowel alone, an *enterocele*; if both are present, *enteroepiplocele*.

Of 76 cases of inguinal hernia operated upon in female children, 24 contained the ovary, tube, or both. The degree of hernia varies from a complete descent of the ovary and tube with the broad ligament to a condition where the ovary and tube lie at or just within the abdominal ring. To reduce the contents, it is necessary to divide the attachment of the infundibulopelvic ligament on the posterior wall of the sac. E. Scott Carmichael (Jour. Obstet. and Gynec. of Brit. Empire, July, 1906).

In about 700 operations for hernia in the female, the ovary was found herniated alone in 4 cases, the tube alone in 1 case, the tube and ovary in 7 cases, and the uterus and tube in 2 cases. Hilgenreiner up to 1905 was able to find reported but 37 cases of hernia of the uterus and his statistics showed it to have occurred most frequently in middle-aged women who had borne children. In nearly one-

half of the cases reported the trouble was associated with defects and malformations of the genital organs. The diagnosis is seldom made before operation except in cases complicated with pregnancy. W. B. Coley (Med. Record, July 26, 1913).

Forty-nine operated cases of hernia of the bladder collected in the literature. The diagnosis is often uncertain. In 17 cases the bladder was injured at operation, but no patient died from this cause. Finsterer (Beiträge z. klin. Chir., Bd. lxxxii, v., von Hacker Festschrift, 1913).

The writer has been impressed by the remarkable frequency of hernia in wartime, probably because of loss of adipose tissue, together with the greater amount of roughage in the bowels, and often the unaccustomed physical labor for those past youth. The number of cases of incarcerated hernia is also greater. Femoral hernias have increased out of all proportion, and gangrene develops exceptionally rapidly after incarceration. Thirty-four died out of the abdominal wall hernias forming 11.5 per cent. of Riedel's total 550 hernia cases. The unusual prevalence of abdominal wall hernias is attributed to the stronger peristalsis caused by the war diet. König (Deut. med. Woch., Jan. 4, 1917).

ETIOLOGY.—About 25 per cent. of persons with a rupture give a family history of hernia. While 40 per cent. are ruptured before the age of 35, 60 per cent. of ruptures occur after that age.

The occupation is an important factor in causing hernia, those trades requiring the most severe muscular effort having the highest proportion of persons ruptured. The increased liability to muscular strain in men is undoubtedly an important factor in explaining the greater proportion of ruptures in male than in female subjects. Parturition is a frequent cause

in the female, especially of umbilical hernia.

Anything that tends to weaken the abdominal walls may be the indirect cause of hernia; for example, traumatism followed by the formation of cicatricial tissue, contusions, obesity, ascites.

Among the conditions which increase natural weakness of the abdominal wall are diseases impairing the nutrition of the muscles, such as rickets; systemic maladies producing great emaciation; abdominal tumors; pregnancy; accumulation of fat in the omentum and peritoneal tissue; relaxation of the parietes incident to old age, and, finally, repeated efforts in lifting or dragging heavy weights.

Potent factors in augmenting intra-abdominal pressure are cough, vomiting, and straining to empty the rectum or bladder. Bronchitis, emphysema, asthma, and whooping-cough are not uncommonly the immediate exciting cause of hernia. Elongation of the mesentery has also been considered a factor in its production. W. L. Rodman and C. W. Bonney (*Amer. Jour. Med. Sci.*, Dec., 1909).

The chief exciting cause of hernia is a sudden strain; the larger proportion of hernias, especially in adult life, come on soon after some unusual effort. The hernia generally begins with a slight fullness over the canal, often associated with a little soreness or feeling of discomfort. In rare cases a fully developed hernia may immediately follow sudden strain.

Hernia in a great majority of instances is the result of long-continued muscular effort, which, along with structural defects, leads to its production. Surgeons attending to railway and allied injuries, seeing thousands of accidents where every form of intense and sudden muscular effort has been made, find rupture as a complication so remarkably infrequent that he is forced to the conclusion

that sudden muscular effort can never be a cause. W. B. Outten (*Intern. Jour. of Surg.*, Feb., 1908).

Replies to a series of questions circulated among about 70 leading surgeons in England, bearing on the relation of hernia to injury, summarized as follows: Oblique inguinal hernia may develop suddenly. This is uncommon and results from a "strain" of the nature of a lifting effort. A scrotal hernia cannot develop suddenly. A sudden hernia is quite small at first. If the hernial sac is acquired, sac and contents cannot appear suddenly as the result of a strain. Symptoms would accompany the sudden first appearance of a hernia, viz., pain, tenderness, tumor, inability to continue work, etc. It could not occur unnoticed by the person affected. Similar symptoms would occur if the hernia were present before, and were suddenly increased in size as a result of the strain. William Sheen (*Practitioner*, Sept., 1909).

The great increase in our knowledge of hernia due to the large number of operations performed during the last two decades has tended to prove that the most important and most frequent cause is the presence of a congenital or preformed sac. This preformed sac is present in practically all oblique hernias and in many direct and femoral hernias. The open funicular process of peritoneum is thus the actual and important cause of nearly all hernias, and the sudden strain, fall, or unusual effort is merely the secondary cause, forcing a piece of bowel or omentum into a pouch that already existed.

Report of the results of a careful post-mortem examination on 200 bodies, nearly all adults, in which there had been no history of hernia during life. In 47 individuals, 30 males and 17 females, there were found present 68 peritoneal diverticula, or potential hernia sacs. In 16

cases more than one diverticulum was found; 58 of these diverticula were in the femoral, the remainder in the inguinal canal. Murray (Lancet, April 20, 1907).

Between 50 and 75 per cent. of young, apparently normal children present thickening of the spermatic cords due to incomplete closure of the funicular process. The anatomical conditions present in operated cases support the view of a congenital origin, as shown by the relation of the sac to its coverings, and its presence in spite of a narrow canal and a small external abdominal ring. A markedly thickened sac, if small, is suggestive of the embryonic condition. Carmichael (Brit. Med. Jour., Aug. 29, 1908).

The saccular theory of hernia finds support from many facts. Besides the frequency with which, *post mortem*, unoccupied peritoneal pouches are found, and the frequency of hernia in children, especially infants, before the advent of strain could come into play, may be instanced the fact that oblique inguinal hernias in females are always congenital, because in them the broad ligament enters into the formation of the sac, and this would not likely be the case were the sac acquired. Tuberculous peritonitis with excess of fluid in the peritoneum often indicates its presence without other symptoms by causing a hydrocele to become apparent; in view of the very slight increase of intra-abdominal pressure due to a little ascites, the sac must have been pre-existent. In certain developing hernias one sees the contents running down obviously narrow and slender sacs, whereas one would expect, if protrusion were the cause of sac formation, the process would have a blunt and bulky form. The saccular theory supports the view that hernia in infants should be operated upon and that the operation should principally deal with the sac. The view that many of these hernias in children cure themselves spontaneously finds its retort in the fact that con-

genital pouches are so commonly found *post mortem* and so commonly become distended by ascitic fluid. A. MacLennan (Surg., Gynec., and Obstet., Jan., 1910).

The chief etiological factor underlying oblique inguinal hernia in fully three-fourths of the cases is a congenital sac, the result of faulty closure of a part or the whole of the vaginal process. This proposition has been sustained in the last 100 operations in the author's practice.

While it is not possible in many cases to make a positive diagnosis of a congenital sac, the following points are suggestive: (1) glove-finger-like and narrow sac, generally empty; (2) thin wall; (3) absence of subserous fat; (4) trabeculated structure; (5) annular constrictions which often still correspond with the internal or external ring, though frequently the constriction has been displaced beyond the ring; (6) thickening of fundus; (7) fibrous process extending downward from fundus for a variable distance, sometimes attaching to the tunica vaginalis testis; (8) close relationship of sac to vas deferens and spermatic vessels which may be spread over it; (9) sac still enveloped by fibers of the cremaster muscle. William Hessert (Surg., Gynec., and Obstet., March, 1910).

In 709 cases of inguinal hernia, in the male, in children operated upon at the Hospital for Ruptured and Crippled, the history definitely stated the type of the sac. A congenital sac, *i.e.*, a sac communicating with the tunica vaginalis, was found in 284 cases, while in 425 cases the sac was of the acquired type, having no communication with the tunica vaginalis. This is directly contrary to the opinion held by most surgical writers, but up to the present time there have been no statistics of hernia in children sufficiently large to determine this point. It is probable that in the great

majority of cases of so-called acquired sac there is a preformed sac, existing since birth, though not communicating with the abdominal cavity.

Indirect causes of hernia are chronic bronchitis, pulmonary affections in general, and habitual constipation.

In oblique inguinal hernia in infants the writer makes a small incision 1 inch over the external abdominal ring, raises the cord with the finger, and makes an incision through its coats, intercolumnar, cremasteric, and transversalic. He separates the sac well, especially above; draws down after opening it, transfixes and ties off. The reduced portion is cut off and allowed to retract up the canal. If it is a congenital case, he merely ties off the sac above the testicle and below at the external ring; a few horse-hair stitches are all that is required. If the sac is not found beneath the external ring, he cuts the aponeurosis of the external oblique. This is then sutured with catgut. The patient should be on his back for 2 or 3 weeks. A truss may be worn afterward if there is much coughing or vomiting. With this operation little catgut is left in the wound to cause trouble. W. A. Robertson (West. M. News, ix, 17, 1917).

REDUCIBLE HERNIA.

DIAGNOSIS.—A reducible hernia usually presents the following signs: A soft tumor or swelling is found in one of the hernial openings. This swelling disappears on lying down, or on moderate pressure; it gives a distinct impulse on coughing, and usually it is seen to increase in size during the act of coughing or straining of the abdominal muscles.

In most cases there is a history of gradual development, with sensations of discomfort in the region of the swelling, especially noted after long standing or walking. In the early

period of development nothing more than a slight fullness may be found; but as the hernia descends it becomes a well-defined tumor. The character of the swelling varies according to the contents of the sac. If it contains bowel alone, it feels smooth and elastic; the impulse on coughing is well marked and reduction is often accompanied by a gurgling sound. Percussion yields a tympanitic note distinctly different from the flat sound produced in omental hernia. If the contents consist of omentum alone, the tumor is more uneven in outline, gives a lobulated feeling and is entirely without elasticity. Both bowel and omentum may be present, in which case there may be a combination of the physical signs already described. Not infrequently the bowel is perfectly reducible, while the omentum is adherent to the sac. The sensations of discomfort and the dragging pain, which may be very slight in a rupture of small size, may become very marked in a large hernia, especially if the latter be not controllable by truss.

Incomplete inguinal hernia is often the cause of pain, sometimes dull and continuous, radiating from the inguinal region to the back, at others more sharp and colicky. Gas, constipation, and a feeling of fullness are also sometimes complained of. Incomplete hernia in the right inguinal canal has been mistaken for recurring attacks of appendicitis; in other cases "neuralgia of the ilio-inguinal or femoral nerve," or neuritis, has been diagnosed.

The small femoral hernia sometimes causes similar symptoms to those just mentioned. If the trouble is allowed to continue, nervous symptoms, headache, fainting, and emaciation may occur. In adults, umbilical hernia always produces gastric disturbances,

sometimes quite serious. The author has also seen attacks of vomiting, with perspiration and quick pulse, caused simply by brief pinching of the omentum in a tough umbilical-hernia ring. Max Ballin (Jour. Mich. State Med. Soc., March, 1908).

Following diagnostic points between recently acquired and chronic hernias tabulated:—

RECENTLY ACQUIRED HERNIA.	CHRONIC HERNIA.
Hernia cone-shaped, base pointing inward, and apex outward.	Hernia with apex inward; base globular and pointing outward.
Sac shows good muscular tone.	Sac relaxed, flabby, and later puckered.
Absence of pigmentation.	Presence of pigmentation, due to separation of muscular fibers of sac and resulting stasis in superficial veins.
Ring small, thin, and with uneven edges.	Ring large, with edges thickened and smooth, due to friction (in and out movements of viscus).
No signs of adhesions.	Thickening (adhesions) may be present, due to omental hypertrophy above and below ring.
As a rule rather difficult to reduce, but returns easily.	Reducible spontaneously and returns easily on account of large ring unless adhesions exist.
Presence of acute inflammatory signs (heat, redness, soreness, etc.), due to injured peritoneum and torn muscle fibers.	Only source of inflammation is irritation or inflammation of previously formed adhesions.
Inguinal canal normal in outline.	Inguinal canal displaced.
Absence of truss marks.	Truss marks may be present.
Proper-fitting truss should always hold hernia in place.	Best-fitting truss may not hold hernia up.
Pubic hair not disturbed, as no truss has ever been worn.	Pubic hair worn off and curled up.
Constitutional disturbances, as nausea, perhaps vomiting, the result of shock.	No constitutional disturbances, unless strangulation, etc.

Butte (N. Y. Med. Jour., Oct. 19, 1907).

A certain amount of enteroptosis is a part of the pathology of hernia. The recurrent colic, indigestion, and other functional disturbances attending most hernias are attended by the same impairment of health as results from gastroenteric catarrh due to other causes. The backache and general fatigue incident to complete and often incomplete hernia, due to irritation and traction upon the delicate nervous structures in the peritoneal cavity, are often debilitating and causative of semi-invalidism. T. B.

Eastman (Jour. Ind. State Med. Assoc., Aug. 15, 1908).

Collective report of 136 cases in which a hernia was attacked by tuberculous. Either the sac of the hernia alone, or both sac and contents, may be affected. W. L. Rodman and C. W. Bonney (Amer. Jour. Med. Sci., Dec., 1909).

TREATMENT OF REDUCIBLE

HERNIA.—The various methods for the treatment of hernia may be classified as either palliative or operative. Palliative, or mechanical, treatment includes all the various appliances by means of which an effort is made to restrain the contents of the abdomen within the hernial orifice. In the majority of cases mechanical treatment does not aim to close the orifice, though in children and young adults such a result is often obtained, thus effecting a permanent cure.

To reduce a congenital inguinal hernia in an infant, the author advises that the child be held up by his feet. When the hernia has been returned, a pad may be firmly fixed over the inguinal canal by means of a roller bandage, or a broad band of adhesive strapping. If a well-fitting truss is at hand, so much the better. The child's legs should then be tied together, and he should be hung up with his head and shoulders just resting on the pillow. If this be found impracticable, he should at least be kept more or less in the inverted position. Great care should be taken with the diet, and the child should be given rhubarb and soda mixture with ginger and peppermint three times a day. All patent foods are to be stopped. A common cause of meteorism is the pernicious habit of sucking at an india-rubber teat or "comforter"; this should be stopped at once. Owen (Brit. Med. Jour., June 1, 1907).

Trusses.—No description need be given of the great variety of trusses. The object to be accomplished by a

truss should be the complete retention of the hernia without causing discomfort to the patient; there are many forms of trusses which fulfill this object satisfactorily. A good truss should consist of a pad to cover the hernial orifice and a spring or band to hold the pad always in the proper position. Steel is, I believe, the best material for this purpose. A spring should surround the pelvis entirely or in part, and should be so constructed as to retain its place either by its own elasticity or by the aid of a strap. The two forms of trusses which I consider to meet best the requirements of an ideal truss are the so-called Knight, or cross-body, truss and the Hood. Both these varieties may be used for single or double truss, and the Knight is quite as satisfactory in femoral as in inguinal hernia. The Hood pattern can be used only in inguinal.

The pad may be made of hard rubber, celluloid, cork, or of wood covered with leather. Some cases not retained by this variety of pad may be satisfactorily controlled by the substitution of a so-called water-pad. These trusses may be made of any size and may be used in the youngest infants without discomfort. In infants and children great care should be taken that the spring be not too strong. The spring itself may be protected by leather, rubber tubing, or hard rubber. In rare cases—for example, emaciated infants—the worsted truss may serve a useful, but temporary, purpose. For routine work it is much inferior to a properly constructed steel truss.

The truss should be so applied that the pad rests over the internal ring rather than upon the pubic bone. In

scrotal hernia it is better to apply the truss in the horizontal position, care being taken that the contents of the rupture be entirely reduced before the truss is put on. In incomplete rupture this is not so important. In infants and young children the truss should be worn both day and night. In adults it may be, in most cases, removed with safety on retiring. Careful attention to the skin beneath the pad is important, especially in children; frequent bathing with alcohol will be found of great service.

One cannot state definitely how long a truss should be worn. It depends largely upon the age of the patient and the size of the rupture. A very large proportion of infants and young children may be cured if treatment is carried out under favorable conditions.

At the Hospital for Ruptured and Crippled a truss is seldom left off in children until a period of two years has elapsed after the last appearance of the rupture. In infants under 1 year of age the truss may be discarded.

There is a certain class of cases in which no form of truss will retain the rupture. This applies to very large scrotal hernias, with openings sufficiently large to admit four or five fingers. These hernias are usually found in middle-aged and elderly people. Operation is in such cases often contraindicated, and the most we are able to do in the way of affording relief is a scrotal bag made of stout material and supported from the shoulders.

The mechanical treatment of umbilical hernia differs with the age of the patient. In infants and young children no form of belt or truss is satisfactory, for the reason that it

seldom retains its place for any length of time. The treatment used at the Hospital for Ruptured and Crippled is to apply a small pad, consisting of a wooden button-mold covered with leather, to the hernial orifice. This is held in place by a strip of rubber plaster two inches in width, which entirely incloses the abdomen. Care should be taken that the plaster be not applied too tightly, and it should be changed at least every ten days. It seldom causes excoriation, and in most cases the rupture will be found to have disappeared at the end of six months or a year. Very few cases go beyond puberty without being cured, and hence the impropriety of operating upon these cases.

IRREDUCIBLE HERNIA.

Any form of hernia may become irreducible. This condition is, however, more frequently found in umbilical than in any other variety of hernia. It is exceedingly rare in children and young adults, and most frequently found between the ages of 30 and 60. In irreducible hernia the contents are most frequently omentum, omentum alone occurring in 90 per cent. of the cases. Omentum with bowel—enteroepiplocele—occurs next in order of frequency. Enterocoele—bowel alone—may become irreducible with numerous adhesions, but this condition is rare.

Where there is an irreducible inguinal hernia with hard contents and the shape of which suggests the uterus, one should palpate through the vagina to determine whether the uterus is actually involved. Hernia of the uterus is frequently accompanied by malformation of the internal genital organs. If the hernia cannot be reduced, it is best to remove the organ. Cesarean section was

done in 5 cases in which the woman was pregnant; 4 of the mothers died and 1 of the children. In 2 other cases premature delivery was induced, with good results. Cranwell (*Revue de gynéc.*, t. xii, No. 5, 1908).

Where a large irreducible hernia of long standing is finally reduced, serious abdominal distention may follow, with even fatal consequences. If reduction is extremely difficult, it is better to resect a portion of the intestine, up to 3 meters. If this is not done and incarceration results, it may be necessary to remove an even greater portion. Two fatal cases are reported with hernias of 12 and 30 years' standing. Death occurred from congestion of the lungs in 1 case, plus incipient peritonitis in the other. Schönbauer (*Wiener klin. Woch.*, Nov. 6, 1919).

Clinically, irreducible hernia differs but little from reducible hernia, which has already been described, except in the fact that the contents of the sac cannot be replaced in the abdominal cavity.

Persons suffering from this form of hernia are liable to frequent attacks of colic, and are almost always subject to constipation. In this variety of hernia inflammation and strangulation are more likely to occur than in reducible hernia.

TREATMENT OF IRREDUCIBLE HERNIA.—If the hernia is not too large and the patient is a good subject for operation, an attempt may be made to effect a radical cure. Mechanical measures are, as a rule, very unsatisfactory. No form of irreducible hernia can be treated with an ordinary truss without much discomfort. A **truss fitted with a concave pad** often proves satisfactory in irreducible hernia of small size; in umbilical and ventral hernias, a **stout abdominal belt with a circular, flat**

pad, or with a **slightly concave pad** in the hernias of larger size, will furnish all the relief we are able to give for this class of cases.

If the hernia has been down but a few days and there are signs of local inflammation, the patient should be kept in bed for a few days and an **ice-bag** applied. In using an ice-bag in these cases where the vitality of the skin is more or less impaired, one should always see that the ice-bag does not rest directly upon the skin, otherwise serious sloughing may ensue. Gentle **taxis** may be used during the course of this treatment, but it should be of only brief duration and never violent. If the rupture cannot be reduced in one or two weeks, it may be regarded as permanently irreducible, and either operation or suitable mechanical support should be employed according to the nature of the case.

In the case of an infant of 3 months, suffering with an irreducible inguinal hernia for nine hours, the author placed the patient with the buttocks slightly elevated, and blew forcibly into its face. The child stopped crying and the abdomen became relaxed. The blowing was kept up while the hernia was slowly but steadily being replaced by **taxis**, and held in position by a band of adhesive plaster. A. Nussbaum (Münch. med. Woch., July 1, 1913).

In irreducible inguinal and femoral hernia a very large number of patients are good subjects for operative treatment; that is, they are under 50 years of age and the hernia is of moderate size, varying between that of a hen's egg and two fists. The results of operation in these cases are extremely satisfactory, and, as far as my personal experience goes, results have been as good as in reducible hernia

in patients of similar age. On the other hand, not a few cases, especially of umbilical and ventral hernia, are old epiploceles of very large size in very stout women with a great excess of fat in the abdominal walls. In such patients, as well as in those who are weakened by disease of the thoracic or abdominal viscera, operation may not be advisable, our efforts being confined to preventing the rupture from increasing in size. Great improvement in the results has been brought about by the newer methods of operation for umbilical hernia. In particular, the **Mayo overlapping operation** may be advised in many cases which were formerly regarded as inoperable.

STRANGULATED HERNIA.

The term "strangulated" is applied to an irreducible hernia in which the loop of bowel is so constricted as to prevent the passage of fecal contents and to interfere with the circulation.

The most common causes of strangulation are heavy lifting, severe coughing, and straining. It may also be produced by a blow or a fall.

In irreducible hernia strangulation often results from inflammation or engorgement of the contents of the sac, or from adhesions formed between the sac and its contents.

It is unnecessary to mention the various theories that have from time to time been offered in explanation of the way strangulation is brought about. The best and simplest explanation is that of venous engorgement: The walls of the veins being more compressible than the walls of the arteries, blood continues to flow into the imprisoned loop of bowel

long after its return has been cut off. This produces great engorgement and rapid exudation of serum into the hernial sac, which makes reduction more and more difficult. The bowel first becomes of a brighter red, later bluish, then mahogany colored and, finally, just before gangrene sets in, of a dull slate color. The exudate, which at first is clear, after a longer or shorter interval becomes turbid. Gangrene may occur at varying intervals, depending upon the tightness of the constriction, the earliest time within which it has been observed being four hours and the latest two weeks. The fluid in the hernial sac frequently contains bacteria, although in the larger proportion of cases thus far investigated, it has been sterile.

Apparent strangulation of an external hernia may result from a mechanical or paralytic ileus. If symptoms of ileus persist after the operation or reduction of a supposed incarcerated hernia longer than twenty-four hours, one should think of an unrelieved mechanical or paralytic ileus. The prognosis of these cases is unfavorable—7 deaths in 10 cases. Proper interpretation of the clinical picture, early surgical intervention, and exact attention to the anatomical findings are desirable in these cases. Clairmont (*Archiv f. klin. Chir.*, Bd. lxxxvi, S. 631, 1909).

SYMPTOMS OF STRANGULATED HERNIA.—The first symptom is usually pain, referred to the irreducible tumor at the site of the hernial orifice. Upon examination the tumor is found tense and very tender on pressure; it gives no impulse, or at most a slight impulse, on coughing. If the strangulation has existed but a short time, the tumor will give a resonant note on percussion. Later this sign may be absent,

owing to accumulation of fluid in the hernial sac. In some cases the pain is referred to the umbilicus rather than the hernial tumor.

An exception to the rule that pain is most marked at the point of obstruction was observed in the case of a woman with a left reducible femoral hernia of many years' standing and also a recent right strangulated femoral hernia. She had excessive pain and tenderness over the left abdomen, but knew nothing about the condition existing on her right side until her attention was called to it. E. A. Parker (*Med. Times*, July, 1909).



Double direct hernia.

The writer's 15 cases included 1 with intestinal hemorrhage, and 2 with paralytic occlusion, fatal in 1 case. He condemns all attempts at taxis, and urges immediate incision and evacuation of the contents of the loop if there is the slightest doubt as to its vitality. Pneumonia followed the operation in 3 cases, probably the work of the ether superposed on the septic intoxication from the gangrenous lesions in the bowel. E. Stincer (*Rev. de Med. y Cir. de la Habana*, July 10, 1917).

Of all the symptoms encountered in strangulated hernia, vomiting is the most important. Vomiting is always persistent, occurring at longer or shorter intervals. At first the vomitus consists merely of the contents of the stomach; if the hernia is not reduced, it contains bile, mucus, and

finally becomes stercoraceous. Complete constipation is always a symptom of great importance. In rare cases diarrhea may occur as an early symptom. There is always an increase in the pulse rate and usually a slight elevation of temperature, especially in the early cases. Later on the temperature may become subnormal.

Mainly owing to the lower blood-pressure in elderly individuals, incarceration of a loop of intestine is likely not to cause such severe symptoms as in younger patients. In several cases in elderly persons the incarceration had lasted for five or six days without irreparable injury before the operation. Wilms (*Beiträge z. klin. Chir.*, Bd. L, Nu. 2, 1907).

Absence of vomiting noted in a case of strangulated hernia that had lasted four days before seen. The abdomen was greatly distended and tympanitic, and there was considerable pain. Operation revealed a gangrenous intestine involved in the hernia. J. R. Judd (*Jour. Amer. Med. Assoc.*, June 24, 1911).

The following symptoms and signs have been observed in the few cases of retrograde incarcerated hernia reported: Large-sized tumors in the scrotal region, sometimes asymmetrical, due to the distended separate loops; colicky pain in the lower abdomen, on the side of the hernia; pain on pressure on the side of hernia, right above Poupart's ligament; rigidity above Poupart's ligament on the side of the hernia; local tympany; sausage-like mass in the lower abdomen, on the side of the hernia; perceptible asymmetry of the lower abdomen, the hernial side being higher; dullness on percussion of the flanks, due to fluid, and a perceptible fluid wave; Blumberg's sign of peritoneal irritation may be present; greater abdominal than scrotal tenderness. After opening hernial sac: Presence of two or three separate loops of gut; escape of fluid, clear or bloody, from

abdominal cavity, after cutting constricting ring. Because of the extreme rapidity of gangrene in the incarcerated loop, early operation is of great importance. L. Friedman (*Surg., Gynec., and Obstet.*, July, 1913).

In strangulated omental hernia with strangulation of omentum alone—an extremely rare condition—all of the symptoms are milder in character. Constipation may or may not exist.

[I have observed one case of acute strangulated omental hernia in which operation was performed on the third day. WILLIAM B. COLEY.]

DIAGNOSIS OF STRANGULATED HERNIA.—There is no condition likely to be met with in surgical practice in which it is more important to make an early and correct diagnosis than in strangulated hernia. In typical cases, fortunately, the diagnosis is attended with little difficulty. In a hernia previously irreducible, the condition of obstruction or inflammation of the hernial contents may cause one to suspect strangulation. In obstructed hernia, however, the impulse is usually present, pain is less acute, and the other symptoms are much less marked than in the case of true strangulation. The same is true of inflamed hernia. Strangulation sometimes occurs synchronously with the development of a hernia; I have observed 2 such cases. Given a patient with the symptoms of intestinal obstruction, careful examination should be made of all the sites at which a hernia might occur.

Hernial strangulation under one year is more common than later, and the greatest frequency is in the first three months of life. The cardinal symptoms peculiar to infants are violent and uncontrollable screaming, recurrent vomiting (often fecal),

drawn facies, and tendency to both retention of urine and rapid collapse. In the diagnosis one must exclude acute hydrocele and acutely inflamed ectopic testicle. After prompt operation the mortality should be 10 per cent. or less. Taxis is dangerous and usually fails. A. N. Collins (*Annals of Surg.*, Feb., 1913).

Hydrocele of the Cord.—In the young there is a condition to which attention seldom has been called, and that not infrequently in the hands of the general practitioner causes a mistaken diagnosis of strangulation. This condition is hydrocele of the cord. In this disorder the swelling is more tense and cystic to the touch; it is more freely movable, more globular in outline, and has a more sharply defined upper border, which, upon careful examination, shows that it does not enter the abdominal cavity. In a very few cases it may be difficult to differentiate between the two conditions from physical signs alone, but invariably the clinical history of the swelling will render the diagnosis easy. If there is hydrocele of the cord, there will be absolutely no general symptoms, and, if the statements of the parents be of any value, it will be found that the swelling has existed for several days or weeks, which shows the impossibility of its being a hernia.

Volvulus may produce in a hernia signs and symptoms accurately simulating hernial strangulation; or it may be associated with actual strangulated hernia. Miller (*Annals of Surg.*, Feb., 1911).

In a total of 550 hernia cases the writer saw 107 strangulated herniæ, 60 inguinal, and 47 femoral. In 45 per cent. the hernia was reduced and a radical curative operation performed. In 55 per cent. immediate operation for emptying the sac was necessary. In only 6 per cent. was

resection required to empty the sac, and in only 3 per cent. was the vitality of the loop doubtful. There was no relation between the gravity of the anatomical lesions in the herniated viscera and the time at which incarceration occurred. The viscera seemed to tolerate strangulation well, especially in old persons. G. Bolognesi (*Arch. de méd. expér. et d'anat. path.*, xxviii, 403, 1919).

[At the Hospital for Ruptured and Crippled 28 cases have been operated upon for strangulated hernia in children under the age of 2 years (1890-1913). Not a single death has occurred. The youngest patient was aged 13 days and the strangulated hernia had existed fourteen hours. A **Bassini operation** was done and a permanent cure effected. WILLIAM B. COLEY.]

TREATMENT OF STRANGULATED HERNIA.—**Taxis.**—Taxis and operation comprise the only methods of treatment to be considered. Taxis judiciously applied should always be used before operation is advised. Various positions of the patient are supposed to be of advantage in performing taxis. In inguinal hernia the pelvis should be elevated and the thighs flexed; in femoral hernia the thighs should be flexed and slightly rotated inward; in umbilical hernia both thighs should be flexed in order to relax the abdominal muscles. Traction on the tumor, followed by pressure, will often aid in reduction.

[Some, notably Hern, advocate withdrawing the fluid from the hernial sac by means of a fine hypodermic syringe prior to taxis. Out of 33 cases thus treated reduction was accomplished in 29. He advises this method only in cases of recent strangulation and which refuse operation. It certainly should not be advocated as a routine treatment. WILLIAM B. COLEY.]

Violent or prolonged taxis is attended with great risk; the bowel may be lacerated or so severely con-

tused that gangrene ensues. Often the sac has been ruptured by too forcible taxis. Methods of taxis which were perfectly justifiable when the mortality from operative treatment was very high, are no longer to be tolerated.

Following statistics as to acute reduction *en masse* given: Males, 110 cases, or 86 per cent.; females, 18, or 14 per cent. Inguinal, 113, or 83 per cent.; femoral, 22, or 16 per cent.; obturator, 2, or 1 per cent.; umbilical, 0. Inguinal, died, 54, or 48 per cent.; femoral, 16, or 72 per cent.; obturator, 2, or 100 per cent.

Method of reduction *en masse*: By medical man, 50 per cent.; by patient, 28 per cent.; uncertain, 18 per cent.; spontaneously, 4 per cent.

While in acute cases of reduction *en masse* the viscus reduced is almost always small bowel, the less numerous subacute and chronic cases are found among the hernias containing omentum, large bowel, or bladder.

Reduction *en masse* is to be suspected if the signs and symptoms of obstruction persist after reduction of the hernia. The proper treatment of these cases is to operate, either by making an incision in the middle line of the abdomen below the umbilicus when the exact diagnosis is uncertain, or if the cause of the illness can be ascertained, over the region where the hernia was reduced *en masse*, especially if the inguinal canal feels "full." E. M. Corner and A. B. Howitt (Annals of Surg., April, 1908).

Eight cases of rupture of incarcerated hernia during taxis. The latter had been applied by the patient himself in 4, but in 2 it had been very gentle and by a skilled hand. In 1 case the incarceration had lasted less than three hours; the hernia was small and had never caused disturbances, being easily controlled by a truss. Kappeler (Deut. Zeit. f. Chir., c, S. 1-645, 1909).

Report concerning 40 cases of rupture of the bowel from taxis of in-

carcerated hernia. All the patients were over 30. Probably many cases of taxis rupture occur without the knowledge of any medical man, the primary cause of the resulting peritonitis not having been ascertained. The larger number were femoral hernias, generally of long standing. Rupture may occur from taxis even with a sound bowel. In the 40 cases the taxis had been applied by a physician in 14 instances; 10 of the 22 patients operated on were saved. Snger (Beitrge z. klin. Chir., May, 1910).

Case of a woman, aged 69, who had for years suffered from a right inguinal hernia for which she had worn a truss. Twice before the hernia had given rise to symptoms of strangulation. The third time, the patient and her sister, acting with some vigor, after some hours again succeeded in effecting the disappearance of the swelling, but the pain at once became much worse.

At operation, four days later, a large volvulus was found in the right side of the abdomen consisting of upward of five feet of the lower ileum. The bowel was gangrenous, perforated in several places, and the surrounding peritoneum acutely inflamed. The gangrenous portion was resected, and the abdomen drained.

Despite the loss of nearly seven feet of small intestine and the exclusion of the cecum, ascending colon, and part of the transverse colon, the patient remained in fair health. Gordon Taylor (Lancet, June 4, 1910).

Three alternatives are given if the bowel is unreturnable: (1) the damaged intestine may be left in position and a Paul's tube introduced for draining the intestine; (2) resection; (3) lateral anastomosis beyond the extremities of the injured bowel as a by-pass for the damaged coil. The gangrenous part is left in the bottom of the wound. The necrotic bowel will slough off and as the main current is via the lateral anastomosis the fistula will close itself. W. S. Handley (Pract., xcvi, 235, 1917).

In cases that have been irreducible prior to strangulation—as is generally the case in strangulated umbilical hernia—taxis is clearly contraindicated. Likewise in cases where strangulation has lasted for twenty-four hours or longer, no attempt should be made to reduce the hernia.

Following contraindications to taxis referred to: (1) taxis already thoroughly tried; (2) case extremely acute and violent; (3) when several days have intervened; (4) irreducible hernia; (5) stercoraceous vomiting; (6) suspicion of inflammation or gangrene; (7) where a skillful and clean operation can be immediately performed. Hilton (*Jour. Amer. Med. Assoc.*, May 18, 1907).

Taxis should seldom be employed longer than from three to five minutes, and moderate force only should be used. The application of an **ice-bag** (**hot cloths** are preferable in children and old people) may facilitate reduction. In infants and young children it is a good rule, after an unsuccessful attempt to reduce the hernia by taxis, to prepare immediately for operation, and then, if reduction under an anesthetic be not successful, operation may be at once performed without subjecting the patient to a second anesthetization.

Subcutaneous injections of 0.002 Gm. ($\frac{1}{32}$ grain) of **atropine sulphate** useful in cases of strangulated hernia. The patient is placed on a hard table, an ice compress applied over the hernia, and half an hour after the injection an attempt made to reduce by gentle taxis. It is often well to place the patient in the genupectoral position, and to give a second injection if there is further difficulty, but the attempts at reduction should be very gentle. The method is indicated as a preliminary to operation in cases seen very early, and also where operative interference is refused, or contra-

indicated. Tcherkesson (*Hospital*, April 18, 1908).

Report of 4 cases of hernia irreducible by taxis in which spontaneous reduction took place after subcutaneous injection of **atropine**. Rabl (*Münch. med. Woch.*, Oct. 27, 1908).

Before **taxis** the patient must be anesthetized. The loop should be reduced spontaneously by traction from its mesentery, never by applying force directly to the hernia. Pain should be abolished by a preliminary injection of 0.01 Gm. ($\frac{1}{6}$ grain) **morphine**. The patient should draw up the legs, and a small pillow be placed under the shoulders to relax the abdominal muscles. **Ice** or **compresses wrung out from ice-water** or **ether** should be applied to the hernia, and the buttocks raised, the head and shoulders being lowered. The mass of intestines slides down on the diaphragm and the mesentery, through gravity, pulls on the strangulated loop. If reduction is possible these measures will accomplish it in two hours at most. If they fail, direct force would not have done more. Hardouin (*Presse méd.*, Nov. 20, 1909).

Scopolamine hydrobromide used in strangulated hernia to paralyze motor ganglia of intestines. Gases in strangulated portion pass beyond seat of constriction, and reduction is facilitated or occurs spontaneously. Dose not to exceed $\frac{1}{2}$ or $\frac{1}{6}$ grain (0.005 to 0.01 Gm.). Method contraindicated in children. Luxardo (*Gaz. degli Osp.*, June 9, 1910).

Case seen by the writer after 8 hours of strangulation and in bad general condition. The amount of prolapsed bowel was equal in volume to the fetal head, and the circumference of the pedicle was not over 16 c.c.. The writer placed the patient at rest and gave him 1 Gm. (15 grains) of **citrate of caffeine** in small, frequent doses. Under this management the hernia underwent a slow, spontaneous reduction. The caffeine had a special action on unstriated muscle. The writer recommends the

caffeine treatment as rapid and painless. Bernardo Gil y Ortega (*El Siglo Medico*, Jan. 20, 1917).

In irreducible inguinal and femoral hernia the writer reduces the intestinal loops as far as the neck of the sac by pressure with a finger introduced into the vagina or rectum. A sort of aspiration of the gas contained in the gut is thus produced. J. Neumann (*Wiener med. Woch.*, Aug. 17, 1918).

OPERATION FOR STRANGULATED HERNIA.—Incision.—

Instead of the old incision over the most prominent part of the tumor, usually the upper scrotum, it is much better to make the ordinary Bassini incision, parallel to Poupart's ligament, extending only slightly beyond the external ring. This incision is carried down to the aponeurosis of the external oblique, which is slit up about two inches.

Sac.—The sac is next exposed by careful dissection and opened by a scalpel or scissors. On opening the sac a smaller or larger quantity of fluid almost always escapes. The character of this fluid should be carefully noted, inasmuch as this gives an important indication as to the condition of the bowel. If the bowel is simply congested, the fluid will be clear; if inflammatory changes have taken place, it will be turbid, but free from odor; if the intestine is gangrenous the fluid is seropurulent and almost always has an intestinal odor.

Division of Constriction.—Before attempting to reduce the bowel the constriction must be divided. This may be either the neck of the sac or the fibrous structures forming the external ring, which have already been slit up.

By performing the operation as indicated, the constriction caused by

the external ring disappears with the slitting up of the aponeurosis of the external oblique.

[If the real cause of the constriction were the neck of the sac, it would still be impossible to reduce the hernia. In every one of 7 cases of mine (in children) the aponeurosis was widely opened, and this alone was sufficient to render reduction of the hernia easy, which would have been impossible had the constriction been due to the neck of the sac. This view, as I have stated, is directly contrary to the teachings of most writers. Taniel states that, out of 81 cases of strangulated hernia in children which he collected, the neck of the sac was regarded as the cause of the constriction in 58 cases. WILLIAM B. COLEY.]

Management of the Contents.—

The bowel should be treated with the utmost gentleness, and a warm towel should be frequently applied until it is reduced. If the serous coat is still smooth and glistening, it may be safely reduced. A purple or mahogany color—provided the gut has not lost its elasticity—is not a contraindication for replacing it in the abdominal cavity. In case of doubt as to the propriety of returning the bowel, it is well to apply a hot towel for a few minutes, the constriction having been relieved. If the circulation materially improves, it can be returned with safety.

If the peritoneal coat is granular and devoid of luster and remains cold after the division of the constriction, it would be the better plan not to return the intestine, but to allow it to remain in place, protecting it by a sterile dressing. Examination a few hours later will determine whether it has sufficient vitality to permit of its being returned with safety into the abdominal cavity.

In operations for strangulated hernia in which the vitality of the bowel

is in doubt, the author places a layer of **iodoform gauze** three inches in width, against one side of the mesentery, contiguous to the bowel of doubtful vitality, passing it over the bowel, and then down the opposite side of the mesentery. The loop of bowel thus covered is placed just under the abdominal wound. One or two of the ligatures of the wound are left untied, and the end of the gauze, for the length of a foot or more, is allowed to hang out of the wound. The gauze quickly adheres to the peritoneum, adhesive exudate is thrown out in abundance, and if perforation occurs the discharge does not contaminate the peritoneal cavity. After a few days the gauze may be removed without force and a rubber drainage-tube substituted. The resulting fistula usually heals spontaneously. Hall (Amer. Jour. of Obstet., Feb., 1907).

Resection of the intestine in incarcerated hernia is especially necessary when the groove in the bowel remains after reduction, showing that the mucosa has probably been injured beyond repair, and will lose its vitality either directly or secondarily, so that there is liability to subsequent stenosis. Stricture can develop from the mucosa and submucosa alone, the other intestinal layers being still intact. H. Matti (Deut. Zeit. f. Chir., June, 1911).

If the bowel is gangrenous, and there is no doubt that it is unsafe to return it, two methods of procedure may be adopted: **Primary resection** may be performed, or the **gangrenous knuckle may be left in place**. If left in place, there is no need of sutures, as the adhesions will be sufficient to prevent it from slipping back into the abdomen. The gut may be simply opened and the wound fully protected with antiseptic dressing, the gangrenous knuckle may be removed, and the cut ends of the gut fastened to the skin by means of sutures.

Where the viability of the gut is in doubt, the author draws it out through an incision at the lower external border of the rectus muscle and wraps it in a towel or gauze wrung out of hot normal salt solution, to be repeatedly changed. If after the operation for hernia is over the gut has completely recovered, it may be returned; while, if resection is demanded, it may be done more easily and thoroughly through the second opening, without interfering with the recovery of the original hernial site. When, at the beginning, the gut is absolutely gangrenous, it is drawn out and tied off with strong silk, the dead portion cut away, the ends of the gut cauterized with phenol and alcohol, hemorrhage controlled, the parts thoroughly cleansed, and after a change of gloves, an incision made at the border of the rectus. The long ends of the silk are caught in forceps inserted through the second incision and the gut drawn out through the latter, after which the author proceeds to do a radical operation for hernia and, finally, to unite the gut. D. Macrae (Iowa Med. Jour., Sept., 1909).

In the choice of procedures much must be left to the judgment of the operator himself. If he is a surgeon possessing the requisite technical skill, and the patient's condition does not contraindicate a prolonged operation, it is probable that primary resection will give the better result. This is especially true if the amount of intestine is small.

Eighteen cases of **resection and anastomosis** done in gangrenous strangulated hernia, with 8 recoveries—a recovery rate of 45 per cent. Cases of **anastomosis by circular enterorrhaphy** did better than those by lateral anastomosis.

Of 10 cases in which the resection was followed by the making of an artificial anus, there was only 1 recovery; 2 cases were treated by **invagination of the gangrenous or**

doubtful area. Both recovered, but the method is applicable only to small areas of necrotic or doubtful bowel. The mortality in complicated strangulated inguinal hernias was 37 per cent.; complicated strangulated femoral hernias, 66 per cent.; complicated strangulated umbilical and ventral hernias, 80 per cent. Among 216 strangulated inguinal hernias, gangrene was recognized in 8, or 3.6 per cent.; among 133 strangulated femoral hernias, in 12, or 9 per cent., and among 46 strangulated umbilical and ventral hernias, in 10, or 21.7 per cent. Corner (Lancet, June 13, 1908).

A strangulated bowel is to be considered viable when on liberation of the constriction it receives circulation; when the peritoneum is smooth, shiny, and not blistered, whether dark in color or not; and when no thrombi are present in the mesenteric border. If there is rupture, ulcer, perforation, complete mesenteric thrombosis, permanent unyielding stricture, excoriated peritoneum, and blackened bowel which has lost all contractility, the bowel should be condemned. Brown (Lancet-Clinic, Aug. 29, 1908).

In cases of strangulation in which the contents of the hernia are already gangrenous, with phlegmon in the walls of the hernia and pus within the sac, the author advises the formation of an **enteroanastomosis** between the efferent and afferent loops. The hernial sac is merely opened and drained. A fecal fistula always results, which can be closed by a subsequent operation. In 2 cases in which this procedure was employed, the patients were undoubtedly saved. F. Hesse (Zentralbl. f. Chir., Aug. 6, 1910).

Case operated upon for a strangulated crural hernia in which the mesentery of the herniated loop of intestine was found to be disinserted for an extent of about 45 cm. **Resection** of the intestinal loop for about 50 cm. and an **end-to-end anastomosis** was done, an uneventful recovery following. But few cases of mesenteric

disinsertion in connection with strangulated hernia are found in literature. Besides his own there are but 9 cases recorded. Any pathologic condition which diminishes mesenteric resistance may be a predisposing cause; also taxis may aid, as well as the tension of the mesentery itself. There is no special symptomatology. The prognosis is grave and calls for resection. A. Gallo (Semana Méd., Buenos Aires, xxv, 553, 1918).

In patients suffering from prolonged strangulation and who are much prostrated, or when the amount of intestine is very large, it is much safer to leave the gut in place to be dealt with at a subsequent operation. If the operator has had little experience in intestinal surgery, there is no room for debate as to which is the safer procedure. In many cases of femoral hernia the **artificial anus** has been known to close spontaneously.

In general, inguinal and umbilical hernias should be operated on if strangulation has existed for three days and the symptoms have been mild. If they have been severe, it should not be resorted to after twenty-four hours. In femoral hernia, delay after twenty-four hours is inadvisable. Robinson (Brit. Med. Jour., Jan. 5, 1907).

Case of an infant in which strangulation had occurred fifteen days before the child came under observation. The hernia had been noticed since birth. The recovery after operation in this case encourages surgical interference even in apparently the most desperate cases in young children. R. de Gaulejac (Annales de méd. et chir. enfant., July 15, 1909). Among 100 cases of strangulated hernia, 33 were inguinal, 27 in males and 6 in females; 60 femoral, 8 in males and 52 in females; 4 umbilical, all females; 1 epigastric, female. Only in 8 cases of omental hernia was operation postponed for one or more days. There were but 2 deaths. Every

strangulated hernia should be operated upon at once, without attempt at taxis. In active syphilis or infection of the field of operation, however, if there is no special contraindication, taxis should be tried before resort is had to operation. In small children, if there is no general restlessness, an attempt should be made to bring about reduction by elevation of the pelvis. Strangulated hernia should, as a rule, be operated upon under local anesthesia. Van Assen (*Beiträge z. klin. Chir.*, Bd. lxx, H. 2, 1910).

Intestinal Resection in Strangulated Hernia.—The question of intestinal resection in strangulated hernia has not yet been entirely settled, but there is a growing tendency in favor of **immediate resection** under favorable conditions. The question has been fully discussed by Delore and Thévenot (*Revue de chir.*, No. 6, p. 1153, 1909), of Lyons, France, whose views are based upon a very extensive operative experience covering 166 personal cases of strangulated inguinal and femoral hernia.

The results, in their series of cases of strangulation, support their position: Of 101 strangulated crural hernias, 85 were cured, 16 died; of 65 inguinal hernias, 53 were cured, 12 died. Thus, in a total of 166 cases of strangulated inguinal and crural hernia, there were 28 deaths, or a general mortality of 16.8 per cent. Of these 166 hernias, 137 were operated upon without resection, 29 with resection; and, strange to say, the mortality of the 137 cases operated upon without resection was 24, or 17.5 per cent., while in the 29 cases treated by resection, there were only 4 deaths, or a mortality of 13.8 per cent.

That the writers did not abuse in-

testinal resection, by practising it in cases in which there was no indication in order to obtain very favorable results, is shown by the fact that resection was done in only 29 of the 166 cases.

That in strangulated hernias treated by simple reduction the mortality was 17.5 per cent., while in the cases treated by resection it was but 13.8



Femoral hernia in a child aged 7 years.

per cent., is an observation that requires some explanation.

To my own knowledge, no such favorable statistics have ever been obtained, and these successes are attributed by the authors to the following:—

1. Most rigid operative technique.
2. The application, if possible, of the principle, always to operate upon sound tissue. They believe that many of the failures, in previous intestinal resections in strangulated hernia, have been due to the fact that

surgeons generally make such resections too limited.

3. The fact that in cases of doubt they think it better to resect the suspicious intestinal coil, since it is always difficult accurately to estimate its vitality, as was shown in 6 of their own cases in which they practised simple reduction of the coil which had every appearance of being intact, but in which death followed in every instance as a result of intestinal gangrene and peritonitis.

4. Resection of the intestinal coil prevents the later occurrence of intestinal stenosis, adhesions, strangulation by bands, etc., which are by no means infrequent when a doubtful loop is replaced.

I must say that I am in thorough accord with the position taken by Delore and Thévenot, and my own experience is in harmony with theirs. Within the last year I have seen a death in the hands of one of my colleagues from replacing a doubtful loop of intestine in a case of strangulated hernia. The patient lived between two and three weeks, and then died of intestinal paresis and infection.

INDICATIONS AND CONTRA-INDICATIONS FOR THE RADICAL OPERATION.—Children.—

The indications for operation may be classed as follows:—1. Cases of adherent omentum. 2. Cases complicated with reducible hydrocele. 3. Cases irreducible and strangulated. 4. Cases unable to obtain the care and attention requisite for successful mechanical treatment. 5. Cases over 4 years of age, where mechanical treatment has been faithfully tried for a number of years without benefit. 6. Femoral hernia in children, which, though rare, cannot be cured by trusses. I believe

it is seldom necessary to operate upon children under 4 years of age, and the practice of some surgeons of operating upon infants under 1 year is open to serious question.

Umbilical hernia in children should, with very rare exceptions, never be operated upon, for the reason that it is almost invariably cured either spontaneously or by means of mechanical support.

Over 90 per cent. of all hernias encountered by the writer in children less than 12 years of age healed spontaneously or under a non-surgical treatment. The latter consisted of a diet calculated to prevent abnormal intra-abdominal pressure, overcoming factors such as constipation, phimosis, crying, and cough, and in **keeping the child in bed with the foot of the bed elevated** for at least 14 hours each day. There are, however, certain classes of hernia in children which should be operated on, 1, reducible strangulated hernia; 2, hernia complicated with hydrocele of the cord located in the inguinal canal; 3, hernia with omentum or intestine adherent to the sac; 4, hernia with congenital weakness of the tissues which normally should close the inguinal canal; 5, hernia with a tendency to strangulation but without a tendency to spontaneous healing; 6, hernia with cryptorchism without tendency to spontaneous cure. All these cases, constituting only about 5 per cent. of all hernias, require careful removal of the hernial sac and closure of the external wound. Classes 1, 3, and 5, are especially suited for the Anderson method. In Class 2, the hydrocele should be opened and everted. In Class 4 the Ferguson-Andrews-Bloodgood operation is indicated, and in Class 6 the Ferguson-Andrews-Bevan procedure. A. J. Ochsner (St. Paul Med. Jour., May, 1917).

Adults.—1. In a general way, the younger the patient the better the chances of radical cure.

2. Operation is indicated in all young adults, inasmuch as there is little prospect of cure by a truss after the age of maturity. The operation in skilled hands is attended with almost no risk and the chances of a cure without the further need of a truss are excellent (98 per cent.—Mayo).

3. All cases of irreducible omentum in patients that are fit subjects for an abdominal operation.

4. All cases of femoral hernia in which no contraindication is present.

Contraindications.—Very large irreducible hernia in stout persons should not, as a rule, be operated upon. The risks are large and there is little prospect of permanent cure.

INGUINAL HERNIA.

Radical Operation. — The weight of evidence is strongly in favor of the superiority of **Bassini's method** in operating for inguinal hernia. This method, first performed by its author in 1884, was introduced to the profession in 1890. Bassini published 251 cases with 1 death and 7 relapses. It is performed in the following manner: The canal being laid open to the internal ring, the sac is separated, drawn down, ligated, and resected. The closed peritoneum is then returned, the spermatic cord is pushed aside, and the posterior margin of Poupart's ligament is exposed. The border of the rectus and the edges of the internal oblique, the transversalis, and the transversalis fascia are next sutured to Poupart's ligament under the cord. The latter is then placed upon the layer of abdominal wall thus formed, and the border of the external is sutured to Poupart's ligament over the cord, avoiding compression of

the latter. A new canal is now formed for the cord. The wound is then closed.

In **Bassini's operation**, from elevation of Poupart's ligament, there results at times an enlargement of the femoral canal, especially if there be weak abdominal walls. It is better in these cases not to elevate the ligament, but to lower and suture a portion of the rectus abdominis muscle to the ligament; or, to suture first Poupart's ligament to Cooper's ligament, then perform a radical cure for hernia, and follow this by covering



Double inguinal hernia (inoperable).

the whole with a portion of the pectineus adductor muscle. P. Berger (Bull. méd., Dec. 7, 1907).

Appendix found diseased in the great majority of a large number of cases operated on for right inguinal hernia. Exploring and removing the appendix through the internal ring in the course of a herniotomy is usually not difficult. Walter Courtney (Jour. Minn. State Med. Assoc., Jan. 15, 1910).

Pulling the neck of the sac upward away from the mouth of the internal ring in the radical cure of hernia commended. Having ligated sac, leave ends of ligatures long, and thread each upon a needle. Then remove sac. Pass an additional

suture through neck of sac. Coughlin and Young (Interstate Med. Jour., Oct., 1911).

A weak point left by the Bassini technique is eliminated by the writer by slitting the hernial sac, spreading it out, and suturing it over the gap. The neck of the sac is ligated and cut off close. Seitz (Münch. med. Woch., Jan. 2, 1917).

Andrews's Operation.—This is characterized by imbrication of the layers of the abdominal wall. In a similar technique employed by F. T. Stewart, after the internal ring has been made snug by passing sutures through the transversalis fascia, the canal is closed above the cord by suturing the transversalis and internal and external obliques as one layer to Poupart's ligament, the external oblique fascia thus reinforcing the subjacent muscle tissues. The needle is passed through these structures from without inwards, then through the ligament from within outward, a finger meanwhile protecting the femoral vessels. For precise coaptation and greater strength, deep and superficial sutures are alternately introduced. The lower flap of the external oblique is then carried up over the upper flap, sutured to it, and the skin incision closed.

Ferguson's Operation.—This procedure is planned to prevent recurrence due to deficient natural attachment of the internal oblique and transversalis muscles to Poupart's ligament. The incision is semilunar, with convexity upward, beginning over Poupart's ligament, $1\frac{1}{2}$ inches below the anterior superior spine, and ending near the pubis, over the conjoined tendon. The external abdominal ring is then incised to the intercolumnar fascia, and the longitudinal fibers of the external oblique separated over the inguinal canal to beyond the internal ring. The hernial sac having been separated from the cord and internal ring, it is opened, tied high up and cut off, and its stump dropped into the abdominal cavity. The spermatic cord is left untouched unless there is varicocele. Removal of any excess

of subserous fat is recommended. In bringing back the various structures to their normal situations, care is taken to tighten down the stretched transversalis fascia over the cord by means of a continuous or interrupted suture, thus reducing internal ring to small size. The lower margins of the internal oblique and transversalis muscles are then freshened, Poupart's ligament scarified, and the muscles sutured to the ligament two-thirds of the way down the latter. Finally, the external oblique aponeurosis is sutured, restoring the external ring, and the skin incision closed.

Halsted's Operation.—In the newer technique of this operation, incision of the skin and external oblique aponeurosis is first effected as in the Bassini operation. The cremaster muscle and fascia are then incised and the internal oblique muscle exposed. Large veins, if found, are removed after ligation well up in the abdomen, and well above the testicle, but the vas deferens is allowed to remain in its bed. After ligation or purse-string suturing of the hernial sac the latter is pulled outward beneath the internal oblique with a long curved needle attached to the ligating sutures, and the ends of these sutures tied together over a narrow portion of the muscle. The lower flap, consisting of cremaster muscle and fascia, is then carried beneath the internal oblique and sutured, the internal oblique and conjoined tendon next sutured to Poupart's ligament, with the margin of the former tucked under the ligament, the external oblique then closed with sutures, and the incision in the skin finally closed. EDITORS.]

Halsted's method, while it closely resembles that of Bassini, differs in the direction of more complicated technique. The published results, though excellent, are inferior to those of Bassini.

Following **modified Halsted and Bassini operation** for inguinal hernia used for six years with success, patients being able to be out of bed in

two weeks: Divide skin and superficial fascia over line of inguinal canal. Retract and divide external oblique aponeurosis about one and one-half inches above and parallel with Poupart's ligament. Dissect external oblique aponeurosis backward and upward. Dissect lower segment downward to expose internal abdominal ring and inguinal canal. Liberate sac from cord and open it. Ligate and remove all excessive omentum, returning stump and knuckle of bowel into abdominal cavity. Liberate neck of sac at internal abdominal ring and ligate it. Pass head of threaded needle, with the same catgut, through upper angle of wound, taking it through internal oblique and transversalis fascia, drawing stump of sac above internal abdominal ring, and anchoring it, making a so-called "bumper." This brings healthy peritoneum in contact with the internal abdominal ring, giving it more strength. The cord is treated as the case demands.

In closing abdominal layers, the cord is first elevated by a gauze strip and the curved fibers of internal oblique and transversalis stitched to lower segment of external oblique aponeurosis under the elevated cord. Superior segment of external oblique aponeurosis is next brought down over cord and line of union of lower segment of external oblique aponeurosis with internal oblique and transversalis, as low as possible, and attached to the same by a mattress stitch, as in the Mayo method of overlapping the aponeurosis for ventral hernia.

The superficial wound is then closed by a subcuticular catgut stitch. Pyoktanin catgut, Nos. 1 and 2, is quite sufficient to keep the tissues in proximity until union occurs.

With this operation two lines of stitches unite over the inguinal canal, each of which is capable of free relation and union, and there is the least possible chance for deep infection. W. A. Durringer (Texas State Jour. of Med., Oct., 1909).

In some cases of large hernia where the tissues are very slack the modification of overlapping the edges of the rings described by Halsted gives a thicker scar than that formed by merely drawing the edges together. The large sac need not be dissected formally out of the scrotum, except when the contents are almost universally adherent. Then it should be removed with the attached omentum. All bleeding points should be attended to before the wound is closed. If there is still oozing a drain should be introduced for twenty-four hours. Preliminary frequent washings of the scrotum with soft soap and water as hot as can be borne are called for, followed before operation by iodine solution. The latter must be used with caution, as it produces eczema in some cases. A. E. Barker (Lancet, April 12, 1913).

A method has been employed in a large number of cases by Bull and Coley which they have named "suture of the canal without transplantation of the cord," the other steps being identical with Bassini's operation. The results have been nearly, if not quite, as good as in Bassini's. The only advantage of the method lies in the direction of greater simplicity in technique.

After the sac has been tied off well beyond the neck at a point where it has begun to widen out into the general peritoneal cavity, the deep layer of sutures is placed as follows: With a small tape the cord is held up, and the first suture is placed so that it just touches the lower border of the cord, when the latter is brought vertically to the plane of the abdomen; three to four more through the internal oblique and Poupart's ligament will suffice to close the canal to the symphysis pubis. Next the suture above the cord is inserted.

The incision in the aponeurosis is then closed from above downward by a small continuous suture of kangaroo tendon, and the skin with catgut. No drainage is used, and the wound is dressed very carefully with sterile dry gauze and cotton, and a spica bandage. A plaster spica is used in children under 10 years of age. The wound is dressed on the seventh day, and the patients are kept in bed two weeks, and allowed to go out in two and a half to three weeks, wearing a muslin spica bandage until four weeks have elapsed, after which time no support is worn.

All methods in which the sac is allowed to remain behind, to be disposed of in various ways, should be abandoned. If the sac is left behind there is less chance of securing primary union, and it affords no additional security against relapse.

As early as 1892, we employed in a limited number of cases a method identical with Bassini's without the step of transplanting the cord. Since this time 646 cases have been operated upon by this method at the Hospital for Ruptured and Crippled with 15 per cent. of relapses. In many cases of double hernia, the typical Bassini operation was done on one side, and the same operation without the transplantation of the cord, on the other, in order fairly to test the value of the two procedures. This method has been recently brought out under various names and has been advocated as superior to Bassini's method. In our own experience there has been a larger percentage of recurrences in the cases in which the cord was not transplanted, than in those in which the typical Bassini method was employed. In 2122

operations in which the cord was transplanted there were only 0.4 per cent. of relapses.

In 10 cases of very large hernias the author has replaced the testicle on the affected side in the abdominal cavity, enabling him to close up the opening entirely. The results were very satisfactory, and none of the patients has had any inconvenience from the testicle in the abdomen. Bernhard (*Münch. med. Woch.*, Aug. 6, 1907).

In the following hernia cases Bassini's operation fails to meet the requirements of modern surgery: (1) those of inguinal hernia in elderly subjects; (2) those in adult life where there is a constant and severe occupational strain upon the abdominal walls; (3) those in which, although in young subjects, the muscular structures of the part are found at time of operation to be thin, badly developed, or stretched and loose over a large area; (4) those in which the hernia has recurred, especially if after a carefully carried-out operation followed by primary union; (5) those in which the hernia is of such size that the gap cannot be closed without such tension as to produce strangulation of the structures within the grip of the sutures.

Filigree implantation was employed by the author with excellent results in 33 cases, in none of which was there a remote prospect of cure by Bassini's operation. The filigree was made in two sections—pubic and iliac. The pubic is three-fourths inch wide at the narrow end and one and one-half inches at the wide end, this being the usual length of the adult inguinal canal. Every filigree should have not less than 8 loops to every inch of its midrib. The iliac section is so made that its inner third corresponds in shape and size to the outer two-thirds of the pubic section, while its outer end must meet the requirements of the case, being trapezoid, square, or—usually—oblong, and of a total length of from two and one-half

to three inches, as may be found necessary. The wire must be unalloyed silver. These filigrees are so placed that the cord is sandwiched between two layers of filigree in the canal. The area external to the internal abdominal ring is fortified by a filigree of any necessary size. The filigrees should be placed in ether for five minutes and then left in the sterilizer in the center of the boiling area until the moment of implantation, when they are lifted directly into the wound. The operation is at first conducted almost exactly as in an ordinary Bassini. The sac having been dealt with, the cord is held out of the way, and the first two of the sutures which are to approximate the conjoined tendon to Poupart's ligament are inserted. These sutures being held aside, the pubic section of the filigree is placed upon the peritoneum, its narrow end being close to the pubic spine and its wide end at the inner margin of the internal ring. The conjoined tendon is then brought in close contact with Poupart's ligament over the filigree, by the two sutures already inserted, and as many more inserted as are deemed necessary, the bed in which the filigree lies being kept as dry as possible. Where the muscular wall external to the internal ring is strong, the cord is placed in position and the iliac section of the filigree placed beneath the aponeurosis so that its inner end lies over the internal abdominal ring and upon the cord for a space of three-fourths inch, the outer end being carried outward and laid upon the surface of the internal oblique muscle, one or two sutures holding it in place. If weakness exists, the muscular wall is divided from the ring outward for about an inch, and separated from the peritoneum with the handle of a scalpel. Upon this peritoneum the outer end of the iliac section of the filigree is laid, lightly sutured in place, and the muscles united over it. The aponeurosis and skin wound are then sutured. McGavin (Brit. Med. Jour., Aug. 14, 1909).

In all but a few of 250 operations for radical cure of inguinal and femoral hernia, the inguinal canal was left open except for a simple purse-string suture in the fascia lata and pectineus fascia. No patient wore a truss after the operation. Only 9 cases presented themselves for recurrence, and all were cured by a second operation. These did not include a single case of femoral hernia. The results prove that the various methods of suturing the inguinal canal are unnecessary in hernia of any ordinary size. The secret of success in operations for the radical cure is complete removal of the sac. As this can be done without laying open the canal at all in all but a few complicated cases, *e.g.*, some irreducible hernias and cases of retained testes, it is far better to avoid the latter procedure. E. Deansley (Lancet, Dec. 18, 1909).

In very large hernias the author cuts the transverse muscle to form a rectangular, movable, transverse flap about 5 x 7.5 cm. in size. This is twisted to bring the median end down over the inguinal canal and the end sutured to the spine of the pubis and the lower edge to Poupart's ligament. A piece of the sheath of the rectus muscle should always be included in the flap to strengthen the sutures. Excellent results in 15 cases. Ehler (Archiv f. klin. Chir., Bd. xcvi, Nu. 2, 1912).

Good results in the closure of large hernias by means of periosteal flaps derived from the patient's own tibia. The periosteum forms a thick, almost osseous covering which effectually closes the opening. D. G. Zesas (Zentralbl. f. Chir., April 16, 1912).

By a sliding hernia is meant one in which a fixed portion of bowel, the cecum or sigmoid, has descended through the hernial opening into a hernial pouch, in which case the descended portion of bowel is not entirely within the sac, only the anterior and lateral portions being covered by peritoneum. In operating it is noticed that the anterior and

lateral surfaces of the bowel are free, while the posterior portion is adherent. According to the author's procedure, large clamps grasping the sac are placed on either side near the fixed portion of bowel and parallel to its lumen. A second set of clamps is placed above these so that the sac may be cut between the first and second sets. These incisions should run up to or, preferably, beyond the ring, and by this procedure a flap of bowel is left on either side of the bowel. The bowel is then grasped and pulled upward as if to produce traction on the mesentery, and by careful dissection made free from the underlying structure. The bowel is loosened well beyond the ring, taking care not to injure the blood-vessels which lie in a sort of newly formed mesentery. The lateral flaps, having been turned back so as to cover over the denuded area, are sutured at their margin.

After the bowel has been made freely movable, it is returned to the abdominal cavity, and the next step consists in the partial reconstruction of the sac so that it may be sutured or ligated, as in uncomplicated hernia operations. If a triangular space of denuded bowel is thus formed just internal to the ring, it should be closed over by suturing the peritoneum; 15 cases were operated on by this method, of which 10 were sliding hernias of the sigmoid and 5 of the cecum. All were in adult males. In 8 cases there were double inguinal hernias, in 2 instances complicated by femoral hernias. All the cases recovered satisfactorily. W. C. G. Kirchner (*Jour. Mo. State Med. Assoc.*, June, 1912).

When operating upon inguinal hernias in children and young adults, the author always looks for a sac on the other side. Of 18 cases, 10 showed such a sac, one-half to two or three inches long. Any sac found should be ligated, insuring the patient against the possibility of a second operation. E. W. Roughton (*Lancet*, June 8, 1912).

Few, if any, hernias, whether inguinal or ventral, can now be considered incurable. In **filigree implantation** is to be found the only true radical cure (for the severe cases). Of 263 inguinal hernias, 106 were treated by filigree implantation, and of 51 umbilical or ventral, 40. Some patients had undergone repeated operations ineffectually; 11 were over the age of 60. The use of filigree is attended by a slight increase in the danger of sepsis, but suppuration is not an indication for the removal of a filigree. Wires displaced into a sinus should be removed without disturbing the filigree. No belt or truss should ever be applied on the top of an implanted filigree. For the reduction of very large inguinal hernias and the avoidance of paralytic ileus the Trendelenburg position should be used, the abdomen opened, and the bowel withdrawn from within, aided by pressure from without.

In dealing with a gigantic hernia, spinal analgesia should be preferred to general anesthesia. Lawrie McGavin (*Proceed. Royal Soc. of Med.*, Jan., 1913).

The writer urges additional fortification of the inner half of the inguinal canal in cases of hernia in which the conjoined tendon and especially the internal oblique muscle is weak, attenuated, or deficient. His procedure consists of the suture of the inner half of the external oblique aponeurosis to Poupart's ligament after the internal oblique and conjoined tendon have been sutured and the overlapping of the internal half by the external half. After operation there should be moderate elevation of the trunk and thighs, which is easily obtained with the Gatch bed. W. S. Schley (*Annals of Surg.*, lxxi, 753, 1920).

Results of Operation.—Hernia can, for a considerable time at least, be cured by operation. Although no definite time-limit can be laid down beyond which relapse may not occur, a careful study of cases operated upon

enables us to arrive at certain fairly definite conclusions.

It may be stated in a general way that, if a rupture is sound at the end of one year after operation, there is a strong probability of permanent cure, while, if it remains well for two years, the chances of relapse are very small. Ninety-five per cent. is a conservative estimate of cures following Bassini's operation if the operation has been properly performed. This estimate presupposes a judicious selection of cases.

[Some operators openly state that they never select their cases. There is no field in surgery, I believe, in which there is greater need for the exercise of good judgment than in that of operations for the radical cure of hernia. WILLIAM B. COLEY.]

The practice of operating upon all cases of hernia, irrespective of the age of the patient and the size of the hernia, cannot be too strongly condemned.

The mortality attending hernia operations has changed very little since the earlier statistics. From December, 1890, to January, 1901, a period of 10 years, 2732 cases were operated upon at the Hospital for Ruptured and Crippled, with 6 deaths, or .22 per cent. From January, 1901, to January, 1918, 3358 were operated upon with 5 deaths, or .15 per cent. The later deaths referred for the most part to cases of large irreducible strangulated umbilical hernia.

With regard to the end results of the first period the authors report 15 recurrences in 2029 cases of inguinal hernia in the male, or .73 per cent., in the cases operated upon by the Bassini method, and 42.8 per cent. in the small group of cases operated upon by Czerny's method prior to 1891.

In the second period, from 1901 to 1918, covering 2200 cases, there were only 10 relapses or .45 per cent. In this series, as far as it has been possible to trace, 1667 cases have re-

mained well from 1 to 4 years; 586 cases have remained well from 5 to 9 years; 193 cases have remained well from 10 to 14 years; 46 cases have remained well from 15 to 19 years, and 14 cases have remained well from 20 to 26 years.

Of 216 cases of femoral hernia, 169 have occurred in adults and 47 in children under the age of 14 years. Ninety-nine cases have been traced in which the patients have remained well from 1 to 24 years after the operation, and in the entire series 8 recurrences are known to have taken place.

Of 166 cases of umbilical hernia, 118 occurred in adults and 48 in children; of the latter, 21 occurred in males and 27 in females. In 66 cases the patients are known to have been in good condition from 1 to 11 years after the operation, and in 25 cases for more than 3 years. Nine recurrences have taken place and 5 deaths; among the deaths was 1 case, a female 44 years of age in which an extensive operation for carcinoma of the ovary was performed in addition to the hernia operation, and the patient died 4 days later.

Of 103 cases of ventral hernia, 86 occurred in adults and 17 in children. In this series, 41 have remained well from 1 to 15 years, the remainder not having been traced, and 11 recurrences have taken place.

Of 15 cases of epigastric hernia, 12 occurred in children under the age of 14 years, and the remainder in adults. Six cases are known to have been well from 1 to 7 years after the operation, and in 2 cases a recurrence took place.

Among the local sequelæ following radical operations for hernia are: hydrocele and orchitis. Among the general sequelæ: bronchitis, pneumonia, phlebitis, intra-abdominal swelling due to inflammation of omental stump and embolism.

The writers believe that the local sequelæ are in direct proportion to the experience of the operator. If great care is exercised in dissecting the sac from the cord with a mini-

mum of trauma, the larger vessels tied before cutting and the small bleeding points controlled by ligature, hydrocele, orchitis, or local swelling will very rarely be observed. They always make a practice of supporting the testis by a little shelf or platform made of adhesive plaster placed across the upper portion of the thigh.

It has appeared somewhat remarkable that thus far there have been no deaths from embolism in the authors' series of 6500 operations performed at the Hospital for Ruptured and Crippled.

In 1383 adult cases of inguinal and femoral hernia cases operated upon at the Memorial Hospital by Coley and Downes, there were 2 deaths. In the first case, a male 35 years of age, operated upon by Coley, a large mass of omentum was replaced with some difficulty and probably considerable trauma. The patient died on the fifth day with gradually increasing distension and signs of peritonitis. The second case, operated upon by Downes, died of infection and peritonitis. In a third case of umbilical operated upon by Coley at the Memorial Hospital—a very large irreducible umbilical hernia in a stout woman—death occurred. It was found almost impossible to reduce the contents of the sac into the abdomen and when reduced respiration became difficult. The patient died 2 days later of heart failure; no evidence of sepsis. Another death occurred in a case operated upon at the Post-Graduate Hospital by Coley in 1895, in a strangulated femoral hernia with resection of the bowel. Hoguet's service shows 6 deaths; 2 males, 1 a strangulated indirect hernia with general peritonitis present at time of operation, and the other a simple indirect acute, with atrophy of the liver; and 4 females, 1 a strangulated femoral, no resection, shock; another, a strangulated femoral after gut resection; another, a direct inguinal, acute nephritis; and the fourth, a ventral, with pulmonary em-

bolism. W. B. Coley and J. P. Hoguet (*Annals of Surg.*, Sept., 1918).

Roux, of Lausanne, Switzerland (personal communication), has operated upon 1398 cases, with 5 deaths.

Dangers and Complications of the Radical Operation.—The chief dangers to be guarded against are pneumonia and wound infection. Prior to 1890, in the larger proportion of fatal cases, death was due to wound infection; but at present, with the gradual perfection of technique, I consider pneumonia from the anesthetic the greater source of danger. The mortality has been gradually reduced from about 6 per cent., in cases prior to 1890, to less than 1 per cent. in cases operated upon during the last decade. We have collected 8000 cases operated upon since 1890, showing a mortality of less than 1 per cent.

Precautions.—The greatest care should be exercised in cleansing the skin of the patient, as well as the hands of the surgeon and assistants.

We now use the iodine method of preparing the skin in the field of operation and rubber gloves for the operator.

Some form of absorbable material sufficiently durable to permit of tendinous union should be used for all the buried sutures. Kangaroo tendon, on account of its strength and pliability, may be regarded as superior to chromicized catgut. Catgut, if properly chromicized, may be nearly as good, but, as usually prepared, it is more harsh than the tendon and is more likely to cause irritation and subsequent production of a sinus, as is so frequently the case with non-absorbable suture material. My ob-

jections to non-absorbable sutures, including silk, silkworm gut, and silver wire (advocated by me in 1895) were based upon the observation of 16 cases in which the use of sutures was followed by the formation of sinuses and extrusion of the sutures. These sinuses often required many months to heal, and the prolonged suppuration so weakened the canal that in most cases relapse followed. This opinion has been further confirmed by more recent observations.

Suppuration after the Bassini operation can be due to oozing of blood in the deeper structures about the internal oblique and transversalis muscle or under the skin after the operation.

To obviate this, the utmost care should be exercised to stop oozing by compression and suture ligatures with very fine silk or catgut at the operation. When the wound is closed, a gauze roll is made an inch in diameter, and applied directly on the incision, covered by a pad two inches wide, which is secured in turn in two places by one-inch adhesive plaster. Over this is applied the regular wide section dressing of gauze and absorbent cotton, fastened in position by broad adhesive straps, snugly applied. The pressure produced by these straps is multiplied on the line of incision, tending to arrest further any capillary oozing, cause all secretions immediately to pass into the dressing, and obliterate all dead spaces. In addition the limb should be at once immobilized with a Liston splint. This is left in place as long as the patient is kept in bed. In 100 cases thus dealt with there was not a single breaking down of the wound by suppuration or other cause. Ernest Laplace (*Med. Bull.*, Jan., 1909).

Operative experience with recurrent herniæ showed that in indirect hernia the usual cause of recurrence is non-removal of the deeper part of the sac. An occasional cause is failure to find a small sac. Some recurrences

are due to a direct hernia, overlooked or developing subsequently. As to operation for its cure, in every case it must be determined whether the hernia is indirect or direct. The sac is most conveniently picked up at the internal ring. The external oblique aponeurosis is incised for 3 or 4 inches from the external ring and the flaps are turned back. The internal coverings of the cord are opened and the internal oblique is divided in the line of the canal for about 1 inch. If a sac is found the outermost part of the neck is reached without retraction. The sac is isolated by splitting the coverings and dissecting them free. It is then opened and, with a finger inside, is pushed forward against the peritoneum and transversalis fascia within the deep epigastric vessels. This shows the size of a direct hernia and the width between the conjoined tendon and Poupart's ligament. The external oblique is closed with the cord in its natural position. A. W. Sheen (*Lancet*, cc, p. 746, 1921).

Fine catgut is employed for the ligation of the arteries and for closing the skin. The catgut is prepared by boiling it in absolute alcohol at a temperature of 210° F. Both catgut and tendon that I have employed during the past 20 years have been prepared by Van Horn & Co., of New York. Bacteriological tests have invariably proved the material sterile.

A 1 per cent. solution of **novocaine** anesthesia proved efficient in 63 reducible, 9 reducible femoral, 2 incarcerated inguinal, and 7 incarcerated femoral hernias,—2 of the latter with resection of the gangrenous intestine—and 4 umbilical and 7 epigastric hernias. Nast-Kolb (*Münch. med. Woch.*, Aug. 18, 1908).

Pagenstecher linen recommended as suture material in cure of hernia. Silver wire is suitable in many recurrent cases and at primary operations when the tissues are poorly developed. Immediate recurrence in uninfected cases is usually due to the use of

chromic gut. Wiener (Annals of Surg., Nov., 1910).

In children up to 16 or 17 years and in neurotic individuals, some form of general anesthesia is as yet a necessary evil in the radical cure of hernia. In young adults, in the aged, and in all strangulated hernias, except in children, general anesthesia should be avoided as far as possible. The author operates under local anesthesia, as described by Mitchell. A strong solution is made by dissolving a hypodermic tablet containing $\frac{3}{4}$ grain (0.05 Gm.) of cocaine and $\frac{1}{400}$ grain (0.00012 Gm.) of adrenalin in 50 c.c. (1.7 ounces) of normal salt solution. A weak solution contains the same-strength tablet in 100 c.c. (1 $\frac{2}{3}$ ounces) of salt solution. These tablets should be sterilized in very small cotton-stoppered vials with dry heat, raising the temperature gradually during one hour to 100° C. Only two tablets are sterilized in each vial and they should be placed in cotton to avoid contact with glass. A hypodermic injection of $\frac{1}{4}$ grain (0.015 Gm.) of morphine is administered a few moments before operation is begun. The essential points of the operation are: (1) careful skin infiltration (strong solution); (2) perfect blocking of the iliohypogastric and ilioinguinal nerves (strong solution); (3) avoiding any unnecessary handling of tissues; (4) absolute prohibition as to gauze dissection; (5) forewarning patient that at this or that point some discomfort may be felt for a moment until a fresh infiltration with the weaker solution can be made. The postoperative course of a patient operated upon under infiltration anesthesia is far more comfortable than with the use of ether. Nassau (Annals of Surg., June, 1912).

Complications. — Orchitis, which occasionally was observed after the Bassini operation in the early days, is almost never seen if the operation is properly performed, with little bruising of the testis. In adult

cases it is of great advantage, immediately after operation, to apply a strip of rubber plaster, about two inches wide, across the thighs in such a way as to form a support for the testes. It prevents any dragging on the cord and adds much to the comfort of the patients.

Injury to the Cord.—If the operation is performed with due care, there is no danger of injuring the cord, even in children. If the bleeding vessels are at once caught and tied, and the wound kept clean, the different layers of tissue can be recognized as easily as in a dissection on the cadaver. Bassini's operation cannot be properly performed unless this be done.

Atrophy of the Testis.—When Bassini's operation was first introduced, atrophy of the testis was regarded as a possible danger, and this deterred some surgeons from employing the method. Not a single case of atrophy of the testis has been observed in over 3000 Bassini operations at the Hospital for Ruptured and Crippled. I have seen, however atrophy of the testis follow secondary operation for recurrence in which many of the veins had to be sacrificed. Cases of atrophy have been occasionally observed after Halsted's operation, by Dr. Halsted himself, as well as by other surgeons. O'Connor very recently reported 20 per cent. of atrophy of the testis in 129 cases operated upon by Halsted's method.

Hernia of a small portion of bladder is not infrequently met with through the femoral or inguinal ring, especially the former, and especially in elderly subjects. There is considerable risk of incising such a pouch of the bladder, and in some cases it is almost impossible to avoid this.

Where the surgeon suspects the condition during operation the diagnosis may be confirmed by injecting water into the bladder through a catheter. If the vesical pouch has been incised it should be carefully sutured and drainage provided; a catheter should not be retained, but the patient given **hexamethylenamine** for several days. Hutchinson (*Lancet*, Nov. 16, 1907).

Injuries to the bladder during operation for hernia are of two classes. The least common form occurs from the presence within the sac of the bladder or a diverticulum therefrom; or, in the paraperitoneal form, the bladder escapes along the side of the hernial sac and is injured when the latter is incised or ligated. The commonest form is probably due to traction upon the sac in an effort to ligate it as high up as possible, with the result that the peritoneum passing from the bladder to the pelvic wall is dragged into the incision, carrying the bladder with it, where it is either ligated, incised, or torn. The author has collected 325 cases. For the purpose of positively identifying the bladder when opened by accident he advocates the routine use of methylene blue for a day or so prior to herniotomy. R. E. Skeel (*Amer. Jour. of Obstet.*, vol. lviii, p. 964, 1908).

Fifty cases of pulmonary embolism after radical cure of inguinal hernia from the literature studied and 1 personal case reported. Local infection was present in several cases. Some authors found the wound normal, but suspected the deeper parts. In the writer's case the embolus resulted from a phlebitis of the spermatic cord in consequence of manipulations during the operation. In 400 or 500 radical operations by the author, phlebitis was observed 4 or 5 times. The femoral vein may become involved in the course of the operation or at the later dressings. The phlebitis sometimes develops on the opposite side. Lesion of the epigastric vein may have been the original cause, the phlebitis extending to the femoral

vein. Extension may occur to the opposite side. Mauclaire (*Archives gén. de chir.*, vol. ii, p. 573, 1908).

Two cases of injury to the deep epigastric artery in hernia operations reported. Unless Poupart's ligament is thoroughly cleared, and traction be made upon its shelving border, the danger of injury to the vessel is intensified. Erdmann (*Annals of Surg.*, Feb., 1909).

Pains and disturbances sometimes following a herniotomy are due to unsuspected injury of the nerves or neuritis. Among 50 patients with bilateral inguinal hernia operated radically, in every instance in which one or more even of the smaller branches of the nerves were involved in the deep suture neuritis followed, sometimes rapidly disappearing, in other cases remaining for a time, and in still others becoming chronic. Mantelli (*Riforma Medica*, Nov. 22, 1909).

INGUINAL HERNIA IN THE FEMALE.

I have personally operated upon 353 cases of inguinal hernia in the female,—170 in adults and 183 in children,—and only 2 in this entire series were direct hernias. Both of these cases occurred in adults; one was operated upon six weeks ago for a double inguinal hernia with the bladder in the sac on the right side. This gives a proportion of 0.6 per cent., or, if we count the adults alone, as there are practically no direct hernias in children, it is 1.2 per cent. Comparing this with the cases of direct hernia in the male, I have operated upon 1776 cases of inguinal hernia in the male, of which 815 were in adults and 961 in children. Among these, I have observed 50 cases of direct inguinal hernia, or about 3 per cent. If we consider adults alone, which is the only correct way, we have 5.5 per cent. in the

male and 1.2 per cent. in the female, which would make direct hernia in the male occur five times more commonly than in the female.

Among the unusual cases of inguinal hernia in the female in our records are the following: Inguinal hernia of tube and ovary, 1 case, aged 12 years; 1 case, aged 6 years; 1 case, aged 3 years; 1 case, aged 48 years. Strangulated hernia of appendix with large amount of exudate, 1 case, aged 35 years. Double direct hernia with the bladder on the right side, 1 case, aged 55 years.

Operative Treatment.—The operative treatment of inguinal hernia in the female has received but little attention from most surgeons. Championnière was the first to urge it. His method was to excise the round ligament with the sac; but this I believe to be entirely unnecessary and not without objection.

The method of operation which I have employed was the same in the entire series of cases, and consists in an operation practically identical with the modified Bassini operation which the late Dr. Bull and I (*Annals of Surgery*, 1895, 1897, and 1898) introduced at the Hospital for Ruptured and Crippled in 1892. The only variation from the typical Bassini operation is that the cord is not transplanted, but allowed to emerge at the lower angle of the wound. In the female, the round ligament is treated in the same way as the cord in the male, in that it is left undisturbed at the bottom of the wound, the internal oblique being sutured to Poupart's ligament; the aponeurosis is then closed, and last of all the skin, as shown in the accompanying colored plates.

[In the *Annals of Surgery*, September, 1909, I discussed the subject of inguinal hernia in the female. I pointed out the fact that this type of hernia constitutes a fairly large percentage of inguinal hernias.

At the Hospital for Ruptured and Crippled, in the last twenty years, we have had 59,404 cases of inguinal hernia, of which 9082 were in the female. I made an analysis of 1692 cases with reference to the age of the patients at the time the hernia was first noticed. I found that in 66 of 1085 adult cases the hernia had existed in infancy or early childhood.

AGE OF PATIENTS AT TIME OF FIRST VISIT TO HOSPITAL.

Age.	Single.	Double.	Total.
Up to 1 year	140	24	164
1 to 5 years	171	21	192
5 to 10 years	150	32	182
10 to 14 years	56	4	60
14 to 21 years	83	11	94
21 to 31 years	164	30	194
31 to 41 years	254	57	311
41 to 51 years	177	54	231
Over 51 years	185	70	255
Age not stated	6	3	9
	1386	306	1692

WILLIAM B. COLEY.]

In the series of 353 cases referred to there was no death and but two relapses, and the large majority of the cases has been traced to their final result. One of the relapses occurred in a woman, of 35 years, two years after operation, and was brought on by very heavy lifting, which caused, at the same time, a hernia on the sound side. The second relapse was anticipated, for the reason that the operation had been performed in a woman aged 35 years, and seven months pregnant, with a very large strangulated inguinal hernia the size of two fists. The sac and outlying tissues, including fasciæ and muscles, were infiltrated with exudate, and the gut was in a precarious condition. The operation was performed as

rapidly as possible, and the wound closed with drainage. Extensive suppuration followed, and, although the patient was delivered of a healthy child at full term, the wound had not become firm enough to stand the severe strain of childbirth, and relapse occurred shortly afterward.

FEMORAL HERNIA.

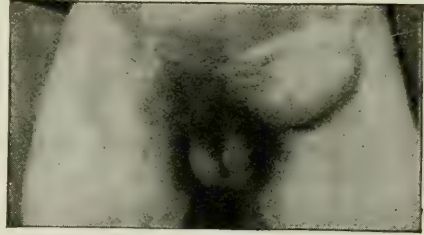
In this variety of hernia the bowel protrudes through the femoral ring underneath Poupart's ligament. It penetrates the femoral or crural canal, the small space extending from the femoral ring to the saphenous opening of the fascia lata. On its inner side is Gimbernat's ligament; on the outer the femoral vein and its floor, as formed by the pubis, covered by the pectineus muscle. The peritoneal sac of a femoral hernia is always acquired. When it advances beyond the saphenous opening it usually becomes much larger. The hernia proper is formed by the skin, the superficial fascia, the cribriform fascia, the sheath of the vessels, the septum crurale, and the peritoneum. Its neck is at the femoral ring, where constriction occurs from the edge of Gimbernat's ligament. Although generally small, it occasionally attains large proportions. Besides intestine, the omentum is often found in the hernial cavity.

The round ligament is frequently in contact with the sac in femoral hernia. It may be (1) adherent to the peritoneum, posterior to the sac; (2) detached from the peritoneum and adherent to the top surface of the neck of the sac; (3) it may pass over the fundus of the sac and cause strangulation of the fatty tissues surrounding the sac. Prolapse of the round ligament is a factor in the production of femoral hernias containing inter-

nal genitalia—most commonly the Fallopian tube. Chevrier (*Revue de chir.*, Feb., 1907).

Femoral hernia seldom occurs before puberty, and is much more common in women than in men.

Of 134 patients with femoral hernia operated on, all but 20 were women. In 2 cases the femoral hernia developed after a radical operation for an inguinal hernia on the same side. This and other experiences suggest the advisability of operating on the femoral hernia through the inguinal ring if it is unusually large, even if there is no actual inguinal hernia at the time. By suturing the muscles to



Femoral hernia.

the horizontal ramus of the pubis, both recurrence of femoral hernia and inguinal hernia are averted. Exalto (*Wiener klin. Woch.*, April 22, 1909).

DIAGNOSIS.—When a femoral hernia is not strangulated, an impulse may be felt when the patient coughs. The tumor is generally tense, small, and round, and can be pushed to the outside of the spine of the pubis.

Inguinal Hernia.—From this variety the distinction is sometimes difficult, especially in women; but the neck of a femoral hernia is always below the spine of the pubis and to the outer side.

Enlarged Lymphatic Glands.—These possess no neck, and several glands more or less enlarged can often be felt. Gurgling cannot be detected; fluctuation through the presence of

pus sometimes renders the diagnosis difficult.

Psoas Abscess.—Gurgling is also absent, but cough also causes an impulse, and the abscess often disappears as in hernia when the recumbent position is assumed. Spinal symptoms usually complicate such cases, however. If a psoas abscess exists, deep pressure in the iliac fossa will detect the tumor after apparent reduction.

Varix of the femoral vein is sometimes misleading, but pressure over it from below upward, sliding the finger over the vein until the femoral ring is reached, causes it to become emptied, after which it may be seen quickly to refill from below,—the differential feature.

Cysts are reducible, but coughing produces no impulse.

Lipomata are bosselated, have no impulse on coughing, and are more doughy to the touch.

Hydrocele and a thickened empty sac are difficult to differentiate, and sometimes require an exploratory incision.

TREATMENT OF FEMORAL HERNIA.—**Reducible.**—An appropriate **truss** involving the principles as to pressure, etc., already outlined, should be employed. A truss is not curative in the case of femoral hernia, however, and is often held in place with considerable difficulty. It should press diagonally upward toward the spine. Compression of the femoral vein, which lies externally to the hernia, must be avoided.

Strangulated.—A strangulated femoral hernia may sometimes be reduced by **taxis** when the thigh is flexed and rotated inward, which position causes the saphenous open-

ing to be relaxed peripherally. No excessive compression or upward pressure should be exercised, however, operation being less hazardous than such a proceeding.

Radical Operation.—Until recently femoral hernia has been regarded as less amenable to radical cure than inguinal; but the statistics would tend to disprove the correctness of this idea.

Numerous methods have from time to time been brought out; many of them are complicated and the majority of them have been supported by a very small number of cases. The inguinal method for the cure of femoral hernia, in which the opening is made in the inguinal canal and the femoral opening closed within the abdominal cavity, has been employed by a number of surgeons. It is, I believe, unnecessarily complicated, and, as long as almost perfect results can be obtained by the simpler methods, I think it should have no place in surgery. There is the additional risk not only of having a recurrence in the femoral region, but through the opening made in the inguinal canal. Various osteoplastic operations have been introduced by means of which the femoral opening is closed by a bony flap.

Most cases of femoral hernia, I believe, can be cured by one of the two following methods:—

1. **Purse-string suture of kangaroo tendon.** This suture is introduced first through Poupart's ligament, the outer part of which forms the roof of the crural canal, then passes through the pectineal fascia, the fascia over the femoral vessels, and lastly upward through Poupart's ligament, emerging about one-fourth centimeter from

the point of entrance. When this suture is tied it brings the floor of the canal into contact with the roof and completely closes the opening. It is very important thoroughly to free the sac before applying the ligature. I have employed this method in nearly 200 cases, with but a single relapse.

2. If the opening is very large, **Bassini's method**, which has given such admirable results for femoral hernia, may be employed: An incision is made parallel with Poupart's ligament and over the center of the tumor. This is the same incision that I employ in the purse-string suture. The sac is dissected free from the canal and ligated as high up as possible; with a curved needle six or seven sutures are inserted so as to unite Poupart's ligament with the pectineal fascia, thus accomplishing the same object that the purse-string suture does. The first suture is placed near the spine of the pubis; the second, half a centimeter externally; the third, one centimeter from the femoral vein, and the remaining sutures are so placed as to bring together the anterior and posterior walls of the canal.

Report of cases of femoral hernia which have remained cured from one to fourteen years after simply dissecting out the sac, ligating it high up, removing the excess, then removing all the fat in the inguinal canal and closing the skin incision. Application of sutures which distort the opening of the femoral canal tends to favor the recurrence of the hernia, rather than prevent it. A. J. Ochsner (Jour. Amer. Med. Assoc., Sept. 8, 1906).

Groin operation for femoral hernia used with very satisfactory results since 1896. An incision four inches in length is made upward and outward from the external inguinal ring, parallel with and a fingerbreadth above

Poupart's ligament, down to the aponeurosis of the external oblique. The lower lip of the wound is pulled down, the hernial sac isolated and followed up as much as possible under Poupart's ligament. The vessels to the outside of the sac must be well cared for, especially if there are adhesions. Next the aponeurosis of the external oblique is opened with the scissors the whole extent of the inguinal canal. The internal oblique and transversalis are raised up, the cord isolated and carried toward the midline along with the surrounding connective tissue. The fascia transversalis is next opened. If the deep epigastric artery and vein interfere, they are cut between ligatures. Through the incision thus made the sac is so separated that it can be brought up from under Poupart's ligament. If the hernia is so large that it cannot be brought back through the femoral orifice, the peritoneum must be opened in the groin, the contents of the sac replaced, and then the sac returned. If the sac contains only adherent omentum, this is ligated and cut off with the sac. The omentum is treated in the same way if it is incarcerated. If intestine is present in an incarcerated hernia, the sac is opened in the femoral region and the fluid contents absorbed with compresses. Then the peritoneal cavity is opened in the groin, the prolapsed organ examined, the cause of the incarceration removed, and the intestine replaced. The empty sac is freed as high as possible, ligated with catgut, and cut off. The peritoneum is then closed. With a curved Reverdin needle a catgut thread is carried almost completely around the femoral orifice, bringing the ligament of Cooper into contact with that of Poupart. Closure of the femoral orifice is completed through the groin wound by suturing the ligament of Poupart to that of Cooper. The abdominal incision is then closed after the method of Bassini. The author has used this method in 7 cases of reducible, 6 cases of irreducible, and 10 cases of strangulated femoral

hernia. No recurrences. Bardescu (Arch. f. klin. Chir., lxxxv, 2, 1908).

Thirty-one cases of femoral hernia operated by incising over the inguinal canal and thus correcting the femoral hernia from the rear. This method is the best, except when the patient is much debilitated or elderly and corpulent, or gangrene is feared. C. Dujarier (Jour. de Chir., Feb., 1912).

In operating radically on femoral hernia, the author makes an incision four or five inches in length parallel with Poupart's ligament, midway between this ligament and the saphenous opening. The fat and areolar tissue is wiped with gauze from the surface of the sac well down and into the external margin of the saphenous opening. The skin and fat of the upper margin of the wound are then pushed upward until Poupart's ligament and the lower fibers of the external oblique come into view. One-half inch above Poupart's ligament and directly above the femoral canal, the fibers of the external oblique are separated, and a gridiron opening made through the internal oblique and transversalis down on the peritoneum. The finger now separates the transversalis fascia from the peritoneum completely around the sac. The peritoneum is then opened through the gridiron incision and an opening also made in the hernial sac. After proper care of the contents of the hernia, the sac is easily pulled up through the canal, tied and cut away. Pulling the lower margin of the wound forward now brings into view the upper margin of the hernial canal, Gimbernat's ligament, the lower border of Poupart's ligament and the iliac vein. One or two sutures of No. 1 chromic gut are made to include the two sides of this triangle; when tied, these completely obliterate the intervening space closing the canal, *i.e.*, the iliopectineal fascia is sutured to the lower border of Poupart's ligament. A running suture of plain gut next closes the gridiron opening, and a subcuticular stitch the skin. Noble (Amer. Jour. Obstet., Mar., 1913).

The principle of the writer's operation is the placing of a ball of fat or other tissue, bigger than the abdominal aspect of the femoral ring, and fixing the ball *in situ*, the ligated sac of the hernia being displaced above the ball. The result of this is that the greater the intra-abdominal pressure, the more this ball is forced against the femoral ring, this effectually closing it. Dowden (Surg., Gynec. and Obstet., Sept., 1918).

In performing **femoral herniotomy by the inguinal route** the writer divides the external oblique aponeurosis through the internal pillar of the external ring; this makes it possible to cover the cord more completely in the last step of the imbrication method of Andrews. To facilitate dissection of the sac it may be necessary to make a vertical incision downward from the original incision and over the femoral swelling. The contents of the sac are reduced through an incision which, if necessary, may be carried clear to the neck of the sac. The empty sac is pulled upward through the femoral ring, a high ligation of the sac done, and the distal portion removed. The external iliac vein is now retracted outward and the inner aspect of the femoral ring exposed and obliterated by 3 chromic catgut sutures, 2 of which are passed through Cooper's and Poupart's ligaments, and the third through Cooper's and Gimbernat's ligaments. The inguinal canal is closed by the Bassini method or the Andrews imbrication method. Eisen-drath (Surg. Clin., Chicago, iv, 49, 1920).

UMBILICAL HERNIA.

VARIETIES.—Three forms of umbilical hernia are usually recognized: the *congenital*, due to faulty union of the visceral plates in the middle line; the *infantile*, which occurs soon after birth as a result of yielding of the umbilical cicatrix after separation of the umbilical cord; and the *adult*,

which usually presents itself late in life in women who have borne many children.

The author divides hernia at the umbilicus into three varieties, according to the time of its appearance. Embryonic umbilical hernia occurs within the three first months of fetal life, and is due to a failure of development of the ventral plates, which never close. Such a hernia has no skin envelope, and is covered by a thin membrane derived from the amnion, an internal serous membrane, and a gelatinous substance between. The liver is often seen in the tumor, which has no sac. The author reports a case of this variety in which the heart was almost vertical in position. The second type of congenital hernia occurs in the later months of fetal life; it is covered by the skin, and has the regular number of envelopes; it is due to non-adherence of the ventral plates at the umbilicus. This form is much less serious than the other. In a paper by Berger, 32 operations are cited, with 26 cures and 6 deaths. The third form is the ordinary one often seen in weak, premature infants; it is of small size, at the navel. Its treatment consists of placing a proper pad and bandage about the body, to be worn for less than four years at most. If spontaneous cure has not taken place by that time operation is in order. Kirmisson (*Med. Rec.*, Feb. 4, 1911).

Congenital Umbilical Hernia.—In this variety the contents can often be seen through the hernial coverings, owing to the thinness of the layers. The hernia, though usually very small, is sometimes quite large from the first, and contains the greater part of the abdominal organs.

Strangulation may occur at the neck through compression of the surrounding tissues, but it has also been caused traumatically by the cord applied around the funis at birth, lead-

ing to a fatal issue if much intestine is involved. A fecal fistula results if but a small portion of gut is lost.

Appendix found in an umbilical hernia in a child, 5 years old, operated for a tumor and fistula at the navel. In addition to tuberculous peritonitis, there was found a tuberculous inflammation of the appendix which had perforated at its apex and communicated by a short, partially obliterated fistula with the navel, and was in the hernia. Flörcken (*Münch. med. Woch.*, Oct. 7, 1907).

Treatment.—**Immediate reduction** should be practised if possible, and **retention** of the intestine insured by the application of adhesive strips over a small pad placed over the opening. Many surgeons advise **immediate closure of the edges of the ring** by catgut sutures. The operation is simple and effective.

Simple laparotomy, with extirpation of the sac and suture of the freshened borders of the wound, is sufficient in a large majority of cases of congenital hernia. The use of several layers of buried sutures is far from easy in the newborn. Congenital umbilical hernia should be operated on as soon as possible after birth, because desiccation of the sac will soon become the starting point of inflammatory attacks in the viscera. If the operation is carried out carefully and without delay, babies will stand the operative shock and anesthesia well. Cumston (*Brit. Jour. of Children's Dis.*, Nov., 1905).

Case of congenital umbilical hernia in which the sac contained the entire small intestine and the cecum firmly united by adhesions. The child was operated on when only 3 hours old, and recovered. S. S. Wilson (*Western Med. Rev.*, April, 1907).

Case of a child born with a very large inoperable umbilical hernia, and still living at the end of two years and four months. The treat-

ment used was the application of **moist warm compresses**. Durlacher (Münch. med. Woch., March 17, 1908).

Review of the reports of 160 cases of congenital umbilical hernia in literature showing that 126 were operated upon, of which 84 recovered and 40 died (results in the other cases not known). W. E. Magrude (Med. Record, Sept. 5, 1908).

Description of a **method used by Nota** for umbilical hernia in 244 children from 2 months to 9 years old. An elastic cord thirty or forty centimeters long is carried around the



Large umbilical hernia in an infant.

base of the hernia with a long, curved needle passed horizontally under the skin. The hernia is reduced and held with the finger while the cord is being drawn tight and the opening obliterated. The ends of the cord are held with a clamp, tied with silk close to the skin and cut off. In a few days the cord cuts through the soft tissues, which grow together in its wake, thus solidly closing the opening, and after twelve or fifteen days the entire cord comes out through the hole in the skin where the ends of the cord protrude, and a thick, solid cicatrix is left. After ten days a dry dressing is applied, and a cloth binder should be worn two or three months afterward. The elastic cord is sterilized by soaking for an hour in 70 per cent. alcohol containing 1.5

per cent. glacial acetic acid. Recurrence observed in only 1 case, cured later by repetition of the procedure. For children other than infants, Nota uses **ethyl chloride**. Brun (Archives de méd. des enfants, Sept., 1912).

Infantile Umbilical Hernia.—This form of hernia, though freely met with, never leads to strangulation and quickly subsides by contraction of the opening if, after reduction, appropriate retentive measures are resorted to.

Treatment.—The hernia should be **reduced**, then **held in place** by means of a cork pad wrapped in cotton wadding, held *in situ* by adhesive strips. When these irritate the skin, or the hernia seems rebellious, a light truss can be utilized instead.

In the small umbilical hernia frequently appearing between the sixth week and third or fourth month of life, the author uses a **roller bandage** of moderately heavy flannel two to two and one-half inches in width and sufficiently long to make three and one-half turns of the body. It is applied by spreading one end upon a table and so placing the child upon it in the recumbent position, that the free end can be brought forward to a point above the iliac spine, directly opposite the navel. This end is now used as a point of resistance in applying firmly but not tightly the first turn of the bandage, which is made to pass exactly over the navel and to grasp the opposing part of bandage as it completes the first turn. The second layer passes a little less than an inch lower than the first, so that its upper margin well covers the umbilicus; the third layer, one inch above the first. The bandage can be adjusted and readjusted according to the needs of the case, once the mother has carefully studied the principle of its use. A. S. Bleyer (Interstate Med. Jour., June, 1908).

Case of a child 6 years old in which the left lobe and most of the right

lobe of the liver were found prolapsed into the cord. The round ligament, found to be holding it, was ligatured and cut and the liver fell back into position. Three deep transverse silkworm-gut sutures were passed through the recti muscles, which were firmly approximated, the umbilical vessels ligated, and the thickened edges of the navel trimmed and sutured, making a vertical wound. A perfect cicatrix was obtained. Mitchell (Lancet, May 13, 1911).

Report of 6 cases of hernia of the umbilical cord, of which 5 were operated upon, usually on the first day of life. That 4 out of 6 children were saved argues for immediate and radical operation. W. Hannes (Münch. med. Woch., Nu. 50, 1911).

In a child 9 days old seen by the writer, the navel showed a sloughing mass about 4 centimeters in diameter. Although the child had a general peritonitis, nothing remained but to resect about 8 inches of small bowel and a portion of the ascending colon. The anastomosis soon healed satisfactorily. The child, however, died on the eighteenth day from the peritonitis. Cullen (Trans. Amer. Gynec. Soc.; N. Y. Med. Jour. Aug. 17, 1918).

Adult Umbilical Hernia.—This variety of hernia protrudes through the linea alba not far from the umbilicus, and is generally observed in stout people, especially women.

Umbilical hernia in the adult may attain enormous proportions, hanging down like a large pouch if allowed to go untreated. The omentum, transverse colon, and small intestines may all be found in it.

Treatment.—When reducible, the hernia is held with difficulty by **trusses**, especially in large subjects. A **broad belt with a pad** fastened to it is sometimes more effectual. It is frequently irreducible, however, and is prone to inflammatory manifestations. When it cannot be reduced, it

is best to protect it by means of a **cup-shaped pad** held in position by a bandage or a belt.

Plea for **early operation** in umbilical hernia. The treatment must practically be prophylactic, viz., must be applied not only before there is any strangulation of the viscera, but before the hernia becomes of extensive proportions. J. W. Kennedy (Jour. Amer. Med. Assoc., Dec. 21, 1912).



Large umbilical hernia.

This variety of hernia is also liable to become obstructed, a complication occasionally leading to strangulation. There is local disturbance and sometimes pain; vomiting sets in and the other manifestations of strangulation already described present themselves.

Taxis should be tried and, if care be taken to empty the hernial intestines of all gas by gentle pressure, often succeeds. If it should not, however, the proclivity of the hernia to rapidly become gangrenous, owing to compression of its vascular supply, renders an **immediate herniotomy** advisable.

Obesity and advanced years are no contraindication in umbilical hernia

to operation. Attempts at reduction should be very cautious, as there is a special tendency to gangrene in these cases. Eschenbach (*Archiv f. klin. Chir.*, Bd. lxxxvi, Nu. 1, 1908).

Use of **paraffin** recommended in umbilical hernia. The hernial sac is raised with the left hand, the contents then sliding back, about 3 or 4 c.c. (48 or 65 minims) of paraffin, heated to 65° C. (149° F.), injected, and the hernia then allowed to spread out again to its original size. **Ethyl chloride** is sprayed for half a minute after withdrawal of the needle, the spot covered with a flat pad of medicated gauze fastened with adhesive plaster. The injected paraffin hardens under the anesthetic, forming a broad plate extending beyond the hernia, holding back the intestines and, by the irritation induced, producing adhesions. Method applicable only to hernias not larger than one centimeter in diameter; if larger, several sittings required. It is important to use only hard paraffin, melting at 54° C. (159° F.). The paraffin later persists unmodified except for the ingrowing of connective tissue into it. Burckhardt (*Fortschritte der Med.*, March 20, 1909).

When **operation** becomes necessary, the skin should be divided over the orifice, remembering that the sac is exceedingly thin and that it may readily be penetrated. Adhesive inflammation often causes the contents to be adherent, another complicating circumstance. To overcome the constriction without opening the peritoneum should be the first aim; if this is impossible, a couple of shallow incisions through the fibrous ring at its lower border, from the inside of the sac, will generally make it possible to reduce the strangulated loop. The adherent omentum should then be liberated, ligated, and removed, and its stump returned. After freshening the pillars of the ring and suturing,

the wound should be closed and drained. Should the gut be gangrenous an artificial anus is the only resort.

The author describes his (**Mayo's**) **operation for umbilical hernia** as follows: Two transverse elliptical incisions are made, exposing the neck of the hernial sac and the aponeurotic structures for several inches above and below it. The neck of the hernial protrusion is cleared as high as the aponeurotic structures extend. The sac is then opened and any intestine which may lie in it is returned into the abdomen. Omentum, if present, is ligated in sections on a level with the peritoneal cavity. The sac, with all of the adherent omentum and skin, is now cut away. A stout curved needle threaded with strong linen is passed from without in through the aponeurotic structures and peritoneum from two to three inches above the margin of the opening. To guard the needle as it enters the peritoneal cavity the bowl of a large tablespoon is a valuable aid. The needle and thread is drawn down and out of the hernial opening. A firm mattress stitch is now caught in the upper edge of the lower flap about one-fourth inch from the margin, the needle carried back through the hernial opening into the peritoneal cavity and made to emerge one-third inch lateral to the point of original entrance. On each side of this is introduced a similar mattress suture of strong chromicized catgut. These three sutures are drawn tight, pulling the entire thickness of the aponeurotic and peritoneal structures behind the upper flap. The margin of the upper flap is now retracted to expose the suture line, and if any gap exist it is closed with catgut sutures. The upper flap is then sutured to the surface of the aponeurosis below by continuous chromicized catgut suture and the superficial fat and skin closed. The patients are confined to bed from twelve to twenty days. Of 75 patients oper-

ated, but 1 had a partial relapse. Another, supposed to have suffered a relapse, was operated upon and a second opening found above and lateral to the closed umbilical opening. W. J. Mayo (Jour. Amer. Med. Assoc., June 1, 1907).

The **Mayo operation** for umbilical hernia is the only one which increases the transverse circumference of the belly at the umbilicus, and therefore increases the size of the peritoneal cavity, so that all the hernial contents can be replaced and accommodated without danger of pulmonary edema and early lung complications from pressure on the diaphragm. It is practically without mortality unless associated with acute complications and is easy and simple in its performance. H. E. Hayd (Intern. Jour. of Surg., Dec., 1909).

Account of **Kelly's modification of Mayo operation** for umbilical hernia. An incision is made over the right and left margins of the hernial opening all the way across and through the strong fibrous sheath of the recti. The author then detaches and raises the sheath from the recti above and below for two or three centimeters. The hernial sac is then freed from the rest of the tissue, opened, and any adherent omentum present removed. If the intestines are adherent they are carefully dissected free, and replaced in the abdominal cavity. The peritoneum is next sewn together with catgut. He then hauls up and sews the free margins of the lower under the upper flap from side to side with four to six interrupted silk sutures (as a permanent support), using, if need be, catgut between them. If the transrectal incision is angled a little upward and the overlapping of the recti well done, there may be little tension; there is always a greatly diminished tension in the overlapping at the ring itself. The free overhanging margin of the upper flap is now sewed by a continuous catgut suture to the fibrous tissues and the supporting part of the operation is completed. This form of

closure is more efficient than any yet devised. The results in 8 cases seem in every way perfect, and there has been no recurrence. Kelly (Annals of Surg., May, 1910).

VENTRAL HERNIA.

"Ventral" is a general term applied to hernias occurring in parts of the abdomen other than the umbilicus, especially those following operative procedures, such as laparotomy. It may also result from abscess of the abdominal wall, defective development, muscular rupture, etc. Strangulation is rarely witnessed, owing to the nature of the orifice. Its treatment is that recommended for umbilical hernia.

Lateral abdominal hernias include those occurring between the costal margin, ilium, and anterior and posterior axillary lines. Effective surgical treatment of these hernias is almost out of the question, except in very small, high, lateral, muscular defects. Support by **bandage and treatment of the associated paralysis** are indicated. Von Baracz (Archiv f. klin. Chir., Bd. lxxv, S. 283, 1908).

Hernia in the linea alba is not to be confounded with the ordinary umbilical hernia or with the visceral protrusions associated with diastasis of the recti muscles following childbirth or ascites. It is more common than is supposed, the author having seen 9 cases in eighteen months. It is unusual to find them under 18 or in extreme old age. Straining and trauma are the commonest causes. A mere **linear incision** over the mass **with removal of the nodule of fat**, if it happens to be a properitoneal hernia, or excision of the sac if it is true hernia, is all that is necessary. Blumer (Yale Med. Jour., July, 1908).

Operation for cure of ventral hernias in stout subjects should be preceded by a course of treatment to **reduce the patient's weight**; this is to last from two to six weeks. During this time the patient spends several

hours each day in reducing or attempting to reduce the hernia, so that at operation the danger from suddenly increased intra-abdominal pressure may be minimized. At times reduction may be accomplished by elevating the foot of the bed.

The steps of the **operation** are as follows: (1) removal of the old skin-scar; (2) clearing the fat from the fascia for two inches in all directions; (3) dissecting the neck of the sac free from the aponeurosis; (4) opening the peritoneal sac and freeing the adhesions for at least an inch inside the hernial opening; there must be no sacrifice of any of the scar-tissue or excessive tissue of any kind except the fat; (5) no attempt is made to separate the flaps into anatomic layers, but the most convenient way of overlapping the flaps one upon the other is chosen, the peritoneal surface of one flap lying on the aponeurosis of the other; (6) the free flap is allowed to drop on to the aponeurosis of the opposite flap and stitched accurately in place. Very careful hemostasis is most essential.

The Rochester clinic has operated upon 242 post-operative ventral hernias. One patient died from acute dilatation of the heart and 13 are known to have had recurrence. Ordinarily fifteen to eighteen days in bed give ample time for healing. A truss should not be ordered, but rather a general abdominal binder. T. S. Judd (*Journal-Lancet*, March 1, 1912).

In a clinical and experimental study of *post-operative* ventral hernia the writer found it to depend on 2 factors, a weak wall and a hernial tendency. The varieties of operation are overlapping, reconstruction, flap inversion, filigree, and free transplantation. In a series of 78 operations, 7 results were not known, 2 treated with filigree were failures, 4 recurred after the overlapping method, and all the others were complete cures. Willard Bartlett (*N. Y. Med. Jour.*, Jan. 22, 1916).

The writer after 500 personal laparotomies, noted 24 post-operative

hernias, all ascribed to weak union of the fascial layers anterior and posterior to the rectus muscles. Below and above the fold of Douglas the transversalis fascia and peritoneum together form the first line of defense. If the fascia is not properly united, the overlying muscle yields, leaving only, as defense, the fascia of the anterior sheath.

Usually the posterior sheath is included in the suture closing the peritoneum, but often it is missed. Between it and the peritoneum is often a half-inch or more of fat. In such cases it is often better to use a second continuous suture for this fascia. Of 260 rectus and midline incisions in clean cases only 3 hernias followed, whereas of 186 rectus and midline incisions for acute intra-abdominal infections, and subacute and chronic conditions requiring drainage, 18 resulted in hernias. A drain up to 3 cms. in diameter at one angle of the wound does not materially increase the danger of hernia. Only 3 hernias could be traced to the site of drainage. In no case was there paralysis of the rectus due to interference with nerve supply. The McBurney incision seems oftener followed by hernia than any other. E. M. Stanton (*N. Y. State Jour. of Med.*, Oct., 1916).

EPIGASTRIC HERNIA.—This is a general term applied to forms of hernia occupying the space between the end of the sternum and the umbilicus. These tumors are sometimes discerned with difficulty, and are apt to cause symptoms usually referred to gastric disorders.

Of special importance in producing gastric symptoms are small epigastric hernias and peritoneal lipomas. The author makes it a rule in all patients complaining of stomach trouble to pass his finger-tips from the xiphoid process down the linea alba, in order not to overlook such small hernias and lipomas. If such a hernia can be reduced, a **bandage**, or **adhesive-plas-**

ter strapping sometimes removes all symptoms immediately. Max Ballin (Jour. Mich. State Med. Soc., March, 1908).

Reference made to 9 cases of epigastric hernia and gastric ulcer. There seems to be an unmistakable connection between the traction and disturbance resulting from an epigastric hernia and the development of an ulcer. Ury (Med. Klinik, April 25, 1909).

The diagnosis of epigastric hernia without palpable tumor is suggested by a history of gastric disturbances and exacerbation of the pain with certain movements, bending over, sneezing, etc. Stomach disturbances with localized tenderness in the median line should always suggest hernia in men whose occupation requires rapid bending and stretching of the trunk or lifting weights. An **exploratory laparotomy** is indicated on suspicion of hernia with severe disturbances. Mohr (Deut. Zeit. f. Chir., July, 1909).

An epigastric hernia may be in or near the linea alba, the linea semilunaris, or in one of the linea transversæ of the rectus. It is usually associated with colic, constipation, vomiting after meals, worse when standing and relieved by lying upon the back. A train of nervous symptoms may supervene. Subperitoneal tumors are differentiated by the absence of gastric symptoms. L. W. Hotchkiss (Annals of Surg., July, 1911).

Case of chronic diarrhea which had yielded to no form of medical treatment, but was cured by operation upon an epigastric hernia. Cobb (Annals of Surg., Jan., 1912).

The size of the hernia and the consequent disability are of much interest, the hernias ranging in size between that of an egg and a child's head. The weakness and discomfort caused by these hernias are very much the same as in hernia following laparotomy.

In regard to the treatment of such cases, much depends on the age of the patient, as well as upon the character of the abdominal wall. As a rule, these patients are young adults with good abdominal muscles, little accumulation of fat, conditions the contrary of which is usually found in umbilical hernia.

The results of **operations** for epigastric hernia are very satisfactory. The same is true of cases following appendicitis. Of 4 cases not one relapsed, though the hernias were of large size and adhesions were present.

Epigastric hernia found to be comparatively frequent in children. There occur periodic pains in the abdomen, directly connected with the meals, especially after breakfast. One of the appendices epiploicæ has worked its way through the linea alba, with consequent traction on the peritoneum. If the hernia persists after systematic use of a **rubber pad** held in place by long wide strips of adhesive plaster, the author advises correction by **injection of paraffin** or a **radical operation**. Brandenburg (Archiv f. Kinderheilk., Bd. lviii, No. 1-3, 1912).

CECAL HERNIA.—This form of hernia is far more frequent than is generally supposed. I have observed it 16 times in 531 operations. In a number of cases the cecum could be reduced, but the appendix could not, on account of adhesions to the sac. Cecal hernia occurs usually on the right side, but may be found on the left. I have operated upon one left inguinal hernia in which the sac contained a large vermiform appendix. The patient was 10 years old. In the majority of cases, especially in young subjects, the hernia is congenital.

The mobility of the cecum and its proximity to the internal ring easily permit its entrance into a patulous vaginal process, either before or after birth, forming an inguinal hernia with a congenital sac. Attachment to the gubernaculum testis or testis itself may drag the cecum into the inguinal canal.

Acquired inguinal hernia of the cecum may be classified as (1) simple, and (2) gliding or sliding. The latter may be subdivided into (a) the intrasaccular; (b) the extrasaccular or parasaccular, and (c) the sacless.

The gliding cecal hernias are produced by a ptosis or downward gliding not only of the cecum but also of the colon, its attachments and vessels, and the posterior parietal peritoneum. About one-sixth of the reported cases of all varieties of inguinal hernia of the cecum were found on the left side. Femoral cecal hernia is generally found in the female sex. Inguinal hernias of the cecum are found at all ages, but are more common at the extremes of life. The symptoms are not characteristic. Strangulation is uncommon.

No single method of dealing surgically with the sac and intestine is applicable for all cases, and the surgeon must be guided by the conditions in each individual patient. The sacless hernias are always small, but usually it is possible, if deemed advisable, to secure a peritoneal covering by a slight modification of **Berger's method** of forming a meso-cecum for extrasaccular hernia. Carnett (Annals of Surg., April, 1909).

Fifteen authentic cases of pericecal retroperitoneal hernia have been reported, 8 being of the subcecal and 7 of the ileocecal variety. Of the latter group only 2, of the former, 3 patients recovered. There are few, if any, features pointing to a distinctive diagnosis. Matthews (Annals of Surg., May, 1910).

RARE FORMS OF HERNIA.—

Diaphragmatic Hernia.—This form may be *congenital* or *acquired*. The

congenital form is due to imperfect closure of the diaphragm and protrusion into the pleural cavity of a portion of the abdominal contents. This occurs by the side of the ensiform cartilage, between the xiphoid and costal portions. A diagnosis of this condition is hardly obtainable.

In congenital diaphragmatic hernia the abdominal organs usually pass in early life into the chest, but symptoms may first arise at any period of life. Dyspepsia and feeling of fullness and cyanosis may occur after meals, followed by rapid recovery. Or, there may be great respiratory embarrassment or strangulation of the intestine.

Most cases are discovered *post mortem* or during operation for some other condition; some (16 per cent.) become apparent on operation for internal strangulation of the intestine. In view of the large proportion of cases which pass through life without serious trouble surgical treatment is to be resorted to only where acute strangulation occurs. E. B. Leech and C. H. S. Redmond (Med. Chronicle, April, 1909).

Report of the clinical history and autopsy findings in a man aged 70 years who died as the result of a congenital deficiency in the central tendon of the diaphragm. The opening was connected directly with the pericardial cavity, the heart at autopsy being surrounded by the entire transverse colon and the great omentum. The patient had never been confined to his bed by sickness before, and on admission presented the clinical picture of an acute right-heart dilatation. The autopsy showed the conditions described, together with evidences of irritation and inflammation in the small intestine, with contiguous reddened and thickened peritoneum. There was no hernial sac. H. S. Martland (Jour. Amer. Med. Assoc., May 15, 1909).

The acquired form may be due to rupture of the diaphragm through

violent effort, direct violence, or penetrating wounds. The penetration through the opening thus formed suddenly creates dyspnea and asphyxia, besides other manifestations which the displacement of organs gives rise to according to the site of the tear or laceration in the diaphragm. Excessive thirst has been noted by Bryant as a prominent symptom.

The most important symptoms of acquired diaphragmatic hernia are: (1) displacement of the heart to the right; this was evident to some degree in all of the cases reviewed; (2) metallic tinkling heard high up in the chest, having relation to the peristaltic movements of the stomach, and not especially corresponding in time to the respiratory movements; (3) tympany of some degree high up in the left chest; (4) absence over the left chest of the dull note indicating fluid, or of the hyper-resonant note of pneumothorax. Murray and Morgan (*Lancet*, Dec. 8, 1917).

Gerster has reported a case of intercostal diaphragmatic hernia, which is relatively rare. The hernial opening in these cases may be as large as the tip of a finger or large enough to admit the entire hand. The hernias vary from the size of a pea to that of an ostrich-egg; usually no sac exists.

Gerster believes the treatment should be mechanical or operative. If operation is done, the procedure should be varied according to the conditions found in the individual case. In some cases, one is not able to make a **layer suture of the diaphragm and intercostal muscles**; in others, one has to **approximate the ribs** above and below, obliterating the space through which the hernia formerly protruded; in others still, a **plastic closure** may have to be restorted to.

Summing up, Gerster states: "In-

tercostal diaphragmatic hernias (1) are usually of traumatic origin; (2) they occur mostly on the left side in the anterior portion of the intercostal spaces (sixth to tenth inclusive)—a region lying between the lower margin of the lung and the free border of the rib from the midline to the mid-axillary line; (3) their symptoms are those common to hernias in general; (4) the X-ray is of great value in determining the relationship of the various parts of the alimentary canal to the hernias; (5) the details of operative treatment vary with the finding in individual cases."

Among recent operated cases of diaphragmatic hernia, the writer found 10 recoveries in 11 operations. In acute injuries, the abdominal route permits better inspection and repair of viscera. The thoracic route is indicated in recent stab wounds of the chest. Simple enlargement of the wound with resection of a rib or 2 may prove sufficient. J. F. Mitchell (*Trans. So. Med. Assoc.*; N. Y. Med. Jour., Apr. 21, 1917).

Keith's own remarks are based on a study of 34 museum specimens in London, 26 of which were of congenital and 8 of acquired hernias. The congenital hernias, he states, are chiefly those which occur at the unclosed pleuroperitoneal passages, of which there were 21, the other 5 being formed by developmental extrusion of the abdominal viscera, principally liver, through the septum transversum. In a certain proportion of the congenital cases he believes it possible to adopt surgical measures for the cure of the condition.

A case of diaphragmatic hernia in an adult was published by Ernest Ringrose in the *British Medical Journal* of Nov. 26, 1910. The in-

stances of patients with congenital diaphragmatic hernia living to adult life are exceedingly rare.

Most diaphragmatic hernias have no hernial sac, hence may properly be called prolapses (220 out of 248). Congenital hernias have a sac, as have also those passing through the esophageal or parasternal orifices. Diaphragmatic hernia is usually due to a direct wound, sometimes to traumatism without a wound. The stomach is the organ oftenest herniated, followed in order by the colon, small intestine, and omentum. In small wounds the omentum usually prolapses first and acts as a guide for the transverse colon, stomach, and spleen. As the stomach is dragged up it undergoes torsion, producing more or less obstruction at both orifices. Usually there is, immediately after the accident, pain in the epigastrium and the left hypochondrium, with a tendency to radiation toward the left shoulder, soon associated with digestive troubles; at times dyspnea and palpitation, with physical signs, and when the hernia is large, with a marked depression in the epigastrium and enlargement of the left side of the chest. Insufflation of air into the stomach and rectum, by increasing thoracic tympany and bringing on dyspnea and palpitation, may often prove valuable in diagnosis. Radioscopy has often been helpful. Displacement of the heart is always suggestive. Vaghinger reports 26 cases of strangulated diaphragmatic hernias treated surgically, with 20 deaths and 6 cures. **Operation** should be practised at once, preferably by the **transpleural route**. Cranwell (*Revue de chir.*, Jan. 10, 1908).

Case of hernia of the diaphragm in which the autopsy showed that the sudden symptoms witnessed had been the result of incarceration of the stomach in the hernia. A perforation was found in the stomach and also in the ascending colon, which was likewise in the hernia. An impor-

tant sign is the presence of gas in the pleural cavity, without metallic sounds. Senna (*Gaz. degli Osped.*, Jan. 31, 1909).

Case of a girl, aged 8 years, complaining of pain in the abdomen and intermittent constipation or obstruction. Eight months before she had had a "severe tumble on to her abdomen." In the hospital she was suddenly seized with acute obstruction, with marked collapse.

At operation the transverse colon in part, some of the descending colon, and the whole omentum had passed through a hole in the left portion of the diaphragm the size of a silver quarter. When the intestine was restored to the abdomen the omentum was found adherent in the chest, and, fearing hemorrhage in dislodging it, it was used to close the hole. The child gradually rallied, but next day developed hematemesis, which persisted until death on the third day. The necropsy revealed firm adhesion of the omentum to the lung. There was no trace of sepsis; the hole in the diaphragm was closed and the bowel undamaged. The stomach showed nothing more than minute hemorrhages. T. C. Litler-Jones (*Liverpool Medico-Chir. Jour.*, July, 1909).

It is important to differentiate between diaphragmatic hernia and elevation of the diaphragm. With a history of severe crushing of the lower thorax or upper abdomen followed by pain, with dyspnea and vomiting, and the physical findings point to displacement of the stomach or intestine into the lower left chest, and displacement of the heart to the right, diaphragmatic hernia is probably present. A bismuth meal and the X-ray will help in the diagnosis. By fluoroscopic examination a paradoxical respiratory phenomenon may be demonstrated as follows:—

During forced inspiration the right diaphragm descends, while the line on the left ascends; during forced expiration the right diaphragm ascends, while the line on the left descends;

upon forced expiration by contraction of the abdominal muscles, the line on the left is again forced high into the chest. This phenomenon is absent in unilateral elevation of the diaphragm. Giffin (*Annals of Surg.*, March, 1912).

Diaphragmatic hernia is much commoner than is generally supposed. Dextrocardia and physical signs suggesting pneumothorax should always cause the possibility of this condition to be thought of and lead to careful radiography of the thorax. Vogel (*Amer. Jour. Med. Sci.*, Feb., 1913).

Congenital hernia of the diaphragm occurs much more frequently than is generally supposed. X-ray offers the best means for diagnosing these cases. Hernial protrusion is usually through a defect in the left side of the diaphragm. The case reported by the writer occurred through the esophageal opening. The greater curvature of the stomach was drawn through the esophageal opening, an **anterior gastro-enterostomy** performed and the stomach was anchored to the esophageal opening by silk sutures. The patient was discharged symptomatically cured. W. A. Downes (*Surg., Gynec. and Obstet.*, xxvii, 393, 1918).

Properitoneal, or Interstitial, Hernia.—There are three varieties of interstitial hernia, according to the relative position of the sac:—

1. The sac lies between the peritoneum and the transversalis fascia. This variety is very rare. A tumor is seldom present, and the condition is not often recognized until strangulation has occurred.

2. The sac lies between the external and internal oblique muscles.

3. The sac is external to the aponeurosis of the external oblique.

In the last two varieties there is a well-marked tumor which is situated in the inguinal region, but seldom extends into the scrotum. While the

mode of formation is in many cases difficult to explain, in most instances the condition is associated with and probably dependent upon an undescended or partially descended testis. In the rare cases of this variety of hernia observed in women it has been associated with a hydrocele of the canal of Nuck; the undescended testis or the hydrocele, furnishing an obstruction to the farther progress of the hernia in the downward direction, causes it to enlarge upward, and, following the line of least resistance, the sac may find its way to the situations already described.

The conditions which may simulate this form of hernia are: a cold abscess from spinal or pelvic bone disease, and hydrocele of the cord. The only form of treatment to be recommended is the operative.

A true fat hernia is a protrusion of a preperitoneal fat mass or lipoma through one of the ordinary hernial apertures. The onset may be sudden. Although not reducible, these hernias are capable of a seeming reduction in a fair proportion of cases. An impulse on coughing can usually be obtained. In very rare instances symptoms of strangulation may result from torsion. The treatment of fat hernia differs in no way from that of the ordinary type, J. Ransohoff (*Lancet-Clinic*, Jan. 4, 1913).

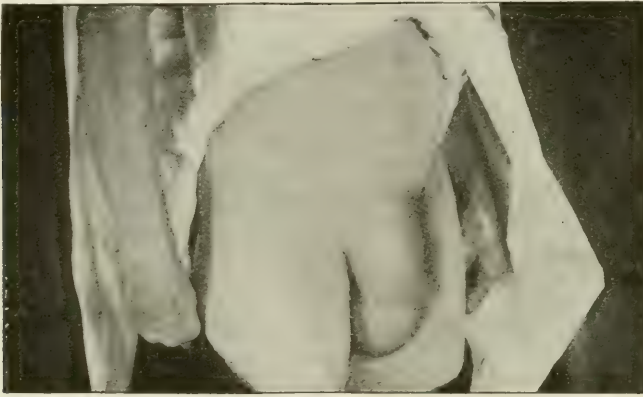
Lumbar Hernia.—This rare form of hernia emerges in the region of Petit's triangle, after passing through the lumbar fascia near the quadratus lumborum, and may result from strains, wounds, abscesses, or appear spontaneously, especially in people of advanced age. It is easily reduced and retained by an appropriate belt.

Case of congenital lumbar hernia first noted at the age of 3½ years. The hernia was about the size of a

goose-egg and bulged on coughing or exertion. Petit's triangle was greatly enlarged. The hernial contents consisted of colon and appendix. There was no recurrence eight months after **operation**. Dowd (*Annals of Surg.*, Feb., 1907).

Hernia into the Foramen of Winslow.—This variety, though very rare, is of special importance, because it frequently gives rise to intestinal obstruction. It cannot be recognized without abdominal section, but treatment of the intestinal obstruction by

Perineal Hernia.—In this form the protrusion occurs between the fibers of the levator ani in front of the rectum; it descends behind the bladder in men, and the vagina in women. It occurs oftener in the latter than in the former and often penetrates the labium majus, forming the *labial*, or *pudendal*, hernia. A true labial hernia also occurs, the sac descending between the ramus of the ischium and the vagina into the posterior portion of the labium.



Labial hernia.

enemata is sometimes successful in bringing about the reduction by causing distention of the gut and traction upon the engaged loop.

Ischiatic Hernia.—This term is applied to protrusions taking place through the lesser sciatic notch, those through the greater being called *gluteal*. It may occur on either side, and may be either congenital or acquired. It has been seen more often in females. Its contents may be bowel, ovary, or a diverticulum of the bladder.

Incarceration of a portion of bowel along with an ovary has been observed in 3 cases. Ischiatic hernia is extremely rare (Garré).

It may be mistaken for Bartholinian abscess and labial cyst, but the inflammatory manifestations of the former and the absence of gurgling in the latter generally render a diagnosis easy.

Winckel, who found 6 cases in 5600 patients examined by him, recommends a **radical operation through the perineal tissues**.

The vagina sometimes becomes a hernial canal. Tendency to this is increased by traumatism, congenital defects, increased intra-abdominal pressure, a displaced uterus, and a vertical vagina. Incipient hernia should be treated by rest, lessening the intra-abdominal pressure, reducing fat, curing cough, the knee-chest position,

tampons, pessaries, etc. If the hernia is extensive, the pelvic floor should be repaired, the cystocele reduced, the vagina made less vertical, and the uterus properly treated. The levator ani muscle should be reunited. C. W. Barrett (*Amer. Jour. of Obstet.*, April, 1909).

Case in which a perineal hernia had apparently arisen from an abnormally deep vesicouterine pouch, passing down between the urethra and vagina. Thence the sac went forward through the posterior wall of the urethra and was extruded through the meatus. Atkinson (*Brit. Med. Jour.*, March 4, 1911).

Obturator Hernia.—This is a rare variety of hernia, which protrudes through the obturator foramen between the obturator externus and pectineus muscles, pushing before it the obturator fascia. The femoral artery and vein pass externally and in front of it, the adductor longus forming the opposite wall. The obturator artery and vein may lie to the inner or outer side of the hernia, especially near the neck,—anatomical features which should be borne in mind when operative procedures are to be resorted to. It is seldom recognized and may be mistaken for femoral hernia.

Its situation causes it to manifest itself in the majority of cases as an indefinite bulging or fullness of the tissues of the region, and careful palpation sometimes causes gurgling. It is usually met with in spare women past middle age and subsequent to the menopause. Men less frequently suffer from this variety of hernia. It is rarely distinguished before strangulation occurs. Pain down the leg along the obturator nerve is a distinguishing feature, in addition to the usual signs of strangulated femoral hernia.

Taxis is sometimes successful, especially if the thigh is flexed, adducted, and rotated inward. The muscles and tissues around the hernia are thus relaxed. If this fails, **herniotomy** should be performed, the nature of the vascular supply and the fact that the constriction is at the neck of the sac—which should be incised by cutting downward—being borne in mind.

Case of obturator hernia in a man 51 years of age, who was taken suddenly with intense pain, at first referred to the abdomen, later extending down the left thigh. At operation, about twenty-four hours after the onset, a knuckle of gut was found so wedged in the obturator foramen that it could not be dislodged. The membrane was nicked and the intestine returned, after having turned in a small gangrenous spot. Keyes (*N. W. Lancet*, June 15, 1907).

If an obturator hernia passes completely through the obturator canal, a swelling may appear just below the pubis within the femoral vessels, above the obturator internus muscle and covered anteriorly by the pectineus. When it does not pass completely through the canal, it either forces its way between the upper and middle fibers of the obturator externus or between the two layers of the obturator membrane, then remaining behind the obturator externus, as well as the pectineus. If it is not palpable, pressure about the junction of the lower and middle thirds of Scarpa's triangle, producing pain, should arouse suspicion of this hernia, especially if it is increased by abduction and internal rotation of the thigh. Rectal or vaginal examination may be of value, as may pain along the obturator nerve. Conditions are not favorable for reduction by taxis. The external operation has many dangers because of the depth and obscurity of the field and the proximity of large vessels. **Lejars operation:** the lithotomy position

and an incision from the inner side of the femoral vessels to the tuberosity of the ischium. When the sac is opened the canal is widened and the bowel reduced. If it is gangrenous it is resected,—a very difficult operation. In some cases the diagnosis of internal obstruction is made, and the **laparotomy** then done serves for the reduction of the hernia. Borszeky (*Beiträge z. klin. Chir.*, Bd. liv, S. 350, 1907).

Report of 12 cases of intra-abdominal hernia in the supravescical space. The patients were all elderly men in the typical cases. Such a hernia causes no disturbance unless it becomes incarcerated, when vague and varying symptoms suggest subacute, sometimes remittent ileus. A distended loop of intestine may be seen above the symphysis. A protuberance in the bladder wall may be revealed by cystoscopy. Operative treatment is imperative if no improvement is observed within twenty-four hours. Reich (*Beiträge z. klin. Chir.*, March, 1909).

Hernias of muscles generally originate from a trauma or sudden violent exertion, though occasionally observed where fascia has been destroyed by morbid processes. The hernia appears usually as a soft, semi-fluctuating tumor, increasing in size and firmness on contraction. Commonly it gives rise to no special discomfort unless after marked exertion. E. Lexer and H. Baus (*Münch. med. Woch.*, Nu. 10, 1910).

The writer employed **fascia lata grafts** for musculocutaneous adhesive cicatrices in 6 cases; muscular and visceral herniæ, 18 cases; covering nerves, 5 cases; and for the reconstitution of tendons with an extensive loss of substance, 4 cases during the recent war.

In muscular herniæ the fascia lata graft has given good results in the writers' experience, and this graft is absolutely indicated. In musculocutaneous adhesions, after freeing the adhesion Bailleul applied the graft; the results were good. Bailleul and

Picot (*Bull. et mém. Soc. de chir. de Paris*, xliii, 950, 1917).

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HEROIN. See OPIUM.

HERPES ZOSTER AND HERPES.—These two disorders,—both the facial and genital varieties,—while not clinically identical, are closely related, according to Schamberg. The histology of the cutaneous lesions and the observed changes in the nerve structures examined appear in all to be practically the same. It is highly probable that the vast majority of all cases of herpes of the various types are the result of the action of a toxin. This proposition necessarily assumes the infectious origin of herpes. The frequency of herpes simplex in certain infectious diseases and its rarity in others is evidence that the toxin must possess certain peculiar qualities in order to exercise a selective affinity for sensory nerve structures. The toxins producing herpes simplex and herpes zoster are, in all probability, not the result of the action of any specific micro-organism. This is certainly true of the former, and by analogy may be assumed to be true of the latter, disease.

HERPES ZOSTER (SHINGLES; ZONA).

DEFINITION.—Herpes zoster is an acute inflammatory disease of the skin, appearing over definite nerve areas, preceded by prodromata, accompanied by more or less severe pain, with usually a unilateral eruption, characterized by the occurrence of groups of firm, tense, globoid vesicles rising from an edematous base, sometimes followed by ulceration and scarring.

SYMPTOMS.—The outbreak of the eruption may or may not be preceded by malaise, fever, and pain. Children are more prone to suffer from malaise. Adults frequently have an initial rigor of no great severity with shivering. The temperature then generally rises, if any variation, to about 100.5° F. (38° C.) in adults and in children to perhaps 102° F. (38.9° C.). Malaise may disappear with decline of temperature as the rash erupts. The feverishness may last from three to five days. Pain is a particular characteristic of the disease, although it is not invariably present, especially in children. It is characterized variously, as dull, heavy, boring, burning, shooting, and sharply lancinating. It usually precedes the eruption; in fact, has been known to occur weeks before, but it also has been known to follow after the lesions have appeared. There may be hyperalgesia first in the area over which the cutaneous manifestation is about to come; or pain alone may be the first indication of the eruptive site. The duration of the pain is variable; it may disappear with the rash, but it is more characteristic to continue afterward, in extreme instances for months, and in elderly people even for years. In children it is ordinarily mild, while in the aged it is apt to be very severe. The pain is frequently worse at night, often causing marked insomnia. The pain in character is severe and steady rather than paroxysmal, and the course is from the posterior root of the skin terminus. Accompanying the pain there is likely to be anorexia, nausea, and in some instances vomiting. The time of the eruption is variable. It may start a few hours

after the onset of the disease, be delayed until the disappearance of the acute symptoms, or it may appear on the third or fourth day. Again, the rash may be fully presented at the end of two or three days after the appearance of the first spots, or continue to come out for a week or so. The vesicles commence to heal a few days after their appearance, but may continue for five or six weeks; if ulcerations are deep, scars mark their original site.

Head prefers to divide herpes zoster into two types, viz.,—*symptomatic zoster* and *spontaneous* or *acute specific zoster*. If the zoster is dependent on some pre-existing disease it may be considered *symptomatic*. It is known to have accompanied myelitis, spinal caries, tabes dorsalis, dementia paralytica, tumors of the cord, and even traumata.

[Under this heading the following case is worthy of citation ("Motor Complications of Herpes Zoster," by Albion Walter Hewlett, Cal. State Jour. of Med., vol. iv, 1906): A young man diving in shallow water struck his head with considerable force. He did not become immediately unconscious, but was unable to move arms or legs. In this condition he sank, became unconscious, and was rescued after being in the water about five minutes. Upon regaining consciousness, twenty minutes later, found arms and legs completely paralyzed. In thirty minutes power began to return to arms; next day arms were very weak. On each arm between elbow and shoulder was an area in which pain and heat senses were lost, tactile sensation remaining unimpaired. Three days later a bilateral cervical zoster appeared, involving the skin distribution of the third and fourth cervical segments. This healed rapidly with fully restored power. Nature of accident, sudden paralysis, dissociated loss of cutaneous sensation, favorable outcome, all form a diagnosis of hemorrhage into the cervical

cord. The zoster was of the symptomatic type. ROSE HIRSCHLER.]

Acute specific or spontaneous zoster appears to be characterized by those symptoms indicative of an acute infection. There is a prodromal period consisting of malaise, fever, and more or less pain. The sudden appearance of eruption; the limited course; the periodicity and epidemicity of the attack, are all indicative of an infection. The pathological

fully formed are unlike those seen in any other disease of the skin. They rise from the surface of the edematous patch freely and distinctly, often having the appearance of being stuck on instead of forming an integral part of the tissues. They are tense, clear, and glistening, are oval or circular in outline, are always in groups, and the roof-wall in each is so firm that they do not ordinarily rupture unless subjected to mechanical violence.

At the outset the vesicles are filled with clear, translucent serum. This, in the course of a few days, grows cloudy in color and later becomes purulent. Hemorrhage sometimes discolors the contents of the lesions. The number of vesicles in each group varies from three or four to one or even two dozen. They are usually from that of a split pea to that of a coffee bean in size, but occasionally when very numerous are not larger than a mustard seed. When small the lesions are much more likely to break down. In most cases from three to a half-dozen groups may be found, but this number may be less or it may be greatly increased. The clusters are generally found following the course of a certain cutaneous nerve; but because of the overlapping of the filaments from different trunks, it is frequently difficult to determine the particular branch which is affected. The distribution is nearly always unilateral, but where the disease is severe the limits of demarcation are not sharply drawn at the median line, and the disorder may trespass upon it to a marked extent. This is due to the extension of nerve-filaments from one side of the body to the other.



Herpes zoster, with facial paralysis. (Ebstein.)

findings, combined with symptomatology, make this type a disease *sui generis*.

The rash is characterized at first by a reddened or bluish-red patch of the size of a half-dollar silver piece or larger.

This area rises to the height of two or three lines, is sharply defined, and is exceedingly tender to the touch. So painful is it that often the friction of the clothing can scarcely be borne. The discoloration deepens and there is a sensation of heat or burning in the patches. In a very short time the vesicles appear.

The vesicles in herpes zoster when

Head says that the whole distribution of posterior nerve-roots is rarely if ever occupied with vesicles, and the whole distribution can only be obtained by including the border of the profound erythema.

A bilateral herpes zoster is generally conceded to be very rare, when no coexisting central nervous disease is present. In no case of spontaneous zoster has the bilateral eruption been at exactly the same level.

[A case of bilateral zoster is reported coincident with Hodgkin's disease. The eruption was attributed to the ingestion of arsenic (Clinical Studies, Edinb., vii, 351, 1909).]

The pain is more decided when the head is attacked than in the regions of the trunk or limbs. In rare instances complete anesthesia of the part follows or anesthesia dolorosa may supervene. Motor as well as sensory disturbances exhibited in local paralyses may occur.

[Case of herpes zoster with facial paralysis and another with sensory disturbances. The writer agrees, with Recklinghausen, that there is a primary affection of vasomotor nerves, the vasodilators being irritated, and looks on the herpes as an intense angioneurotic disturbance which may be associated with diseases of the motor or sensory, spinal or cerebral, nerves.

In most cases the disease results from causes acting on the body in general, though trauma and cold may assist. It is possible that infection or autointoxication plays a part. EBSTEIN.]

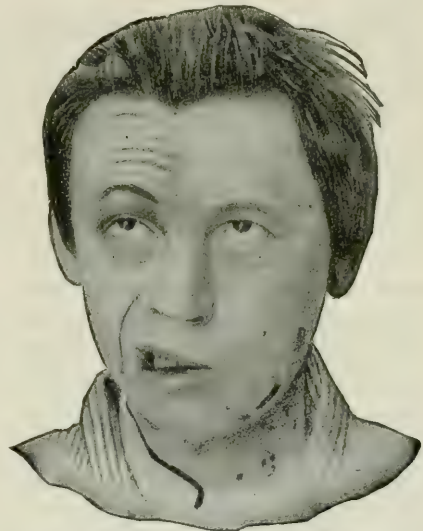
Loss of hair and teeth and atrophy of the muscles have been noticed (Strübing).

Resolution takes place by absorption of the vesicular contents or a crust forms which desiccates and is then exfoliated.

The disease, fortunately, is usually benign, and seldom leaves any tell-

tale symptoms other than cutaneous scars. Second attacks of herpes zoster are rare, but when such occur, the earlier scarring is a proof positive of the first attack.

Indelible scars are occasionally left at the sites of the vesicles. They have a punched-out appearance, as if a nailhead had been driven sharply into the skin and had left its impress upon it, or they may be keloidal. These



Herpes zoster, with facial paralysis. (Ebstein.)

scars should never be mistaken for the relics of syphilis. The disease when attacking the region of the eye is apt to be unusually severe, and death has been known to follow. The eyesight is frequently endangered.

In virulent types of zoster hemorrhage into the vesicles may take place, giving them a bluish or blackish appearance (zoster hæmorrhagicus). An abortive form of zoster, in which the pain appeared in typical manifestation, but without the development of vesicles, has been noticed.

Coalescence of the vesicles often takes place. Where the blebs are

opened, dirty, grayish ulcers are apt to form. These ulcers are decidedly rebellious to treatment and invariably leave scars. Virulent gangrene may take place which may last for months, particularly in the insane. All of the groups do not usually appear at the same time, but come out one after the other at intervals during the first week or ten days. They enlarge somewhat, but seldom unite.

With the exception of inflammation and destruction of the eyeball in part or whole, it is interesting to note that no internal organ of the body has been found to be affected. Cases of zoster coincidental with pneumonia, or other organic disease, have been found over nerve-areas not particularly related to the affected organ.

Regional Zoster.—Herpes zoster may attack any part of the body, but it apparently exhibits a preference for certain sites, and to its appearance in these localities certain names indicative of the region affected are given. Thus we have zoster capillitii, *z. frontalis*, etc. When the disease invades two adjoining regions, more precise terms, such as zoster cervicobrachialis, *z. intercostohumeralis*, and so on, are used. The general features of each are the same, but, owing to anatomical differences, some characteristics need special description.

Zoster is not infrequently found attacking the various regions of the head. In the scalp (*z. capillitii*) the lesions are apt to be the seat of severe burning sensations, the occipital region being most often the part affected. Over the forehead (*z. frontalis*) disfiguring scars are likely to result. The branch of the supra-orbital nerve that passes upward is

here the one that is usually involved. The ear (*z. auricularis*) is sometimes attacked, and the cheeks, side of the nose, and chin are not unusual sites.

Ramsey Hunt has cited cases of herpes situated over auricle and within the meatus, which form is frequently associated with paralysis of the facial nerve. This writer claims that the geniculate ganglion supports the inflammatory lesion, a homologue of the posterior root ganglion. The disease may appear in the mouth-cavity (*z. buccalis*), upon the inner wall of the cheek, and the gums. Zoster exhibits its greatest severity when the eye (*z. ophthalmicus*) is attacked. The first branch of the fifth nerve is then affected. The nasal filament of the same nerve is often implicated and the eruption extends downward upon the nose and cheek. Sir J. Hutchinson says that the appearance of a nasal lesion should make one watchful for corneal ulcerations. The pain is severe. The conjunctiva is reddened and swollen, the cornea is inflamed, and iritis may follow, with marked disturbance of vision and edema of the neighboring parts. In its severer forms disintegration of the eyeball with loss of sight occurs and a resulting meningitis may lead to a fatal issue. Sympathetic involvement of the other eye may take place.

While we must regard zoster of this region as a grave affection liable always to destroy the eyesight and endanger life, yet instances are on record in which the attack, though serious, resulted most favorably. Head has never observed changes in the retina or optic nerve even in the most severe cases. Bowman has never known blindness to follow an attack.

Sattler speaks of rare instances of paralysis of ocular muscles and of ptosis, in some of which cases the herpes was not of the true spontaneous type, but was secondary to some growth or disease about the base of the skull.

Head has seen several cases of zoster involving the third division of the fifth nerve—very rare.

Zoster is more frequently encountered on the surface of the thorax (z. pectoralis) and the neighboring abdominal (z. abdominalis) parts than elsewhere on the body. The right side is more often affected than the left. In the thoracic region the intercostal nerves are attacked. The pain is marked and when occurring before the eruption appears is apt to be mistaken for pleurisy. The presence of fever is needed to establish the latter affection. In zoster of the thorax considerable interference with breathing is liable to be experienced, owing to the pain occasioned by movements of the chest-wall. Duhring notes that the pain here may simulate the distress occasioned in angina pectoris. Because of the peculiar distribution of the diseased areas in these parts in the form of a belt or girdle has arisen the common designations of zoster as zona or cingulum. It is not unusual for the disease to be preceded in this situation for some time before its eruption by its characteristic pain. The nerves affected in abdominal zoster come from the dorsal and lumbar portions of the cord.

Herpes zoster brachialis involves the shoulder and upper arm to the elbow. It may extend down the forearm, and even as far as the fingertips, attacking the palmar surface of the hand; but this is rare. The

flexor surface of the arm is more often affected than is the extensor.

The writer observed a case in which herpes zoster nasofrontalis was associated with extensive paralysis of eye muscles. There developed suddenly pains in the side of head and face and pain and redness in the eye of same side (right). The lid became puffy and a red area appeared on the forehead upon which vesicles formed. Loeffler (Corresp.-Blatt f. schweizer Aerzte, July 13, 1918).

In zoster femoralis the disease spreads over the buttock, thigh, and down the leg. It usually does not go below the knee, and the feet are as seldom attacked as are the hands.

Report of a case of generalized zoster. Two cases observed in elderly men. The patient had severe eruption involving left posterior chest of the distribution of the third dorsal nerve, and anteriorly the left pectoral region and also inside of the left arm and hand. Vesicles were large and some hemorrhagic. There were also scattered vesicles and small, ill-defined papules on right chest, both sides of the abdomen, back, and legs. The lesions numbered about 500. Schamberg (Jour. Amer. Med. Assoc., vol. liv, p. 532, 1910).

Zoster Atypicus Gangrænosus et Hystericus.—Kaposi noted a peculiar form of recurring herpes in a number of cases reported by him to which he gave this name. Three of the subjects were women and one was a man. In all, distinct symptoms of hysteria were present. In each case the eruption consisted of vesicles and papules gathered in groups. A central crust formed in each vesicle, and about it there developed a number of tiny pustules. A number of the lesions coalesced, and gangrene of the part followed. After separation of the slough and healing by granulation

had occurred, keloid formed in many of the cicatrices. The period of development lasted for about eight days, when subsidence began to be evident. Both sides of the body were affected and in all but one case a number of recurrences took place.

DIAGNOSIS.—The recognition of herpes zoster does not usually present any great difficulty. The severity and peculiar character of the pain, the grouping of the large, firm vesicles upon an erythematous base, the lesions running their course without rupturing, and the common limitation of the trouble to one side of the body and over the course of some cutaneous nerve are the distinctive features that differentiate the disease.

At times *herpes simplex* assumes some of the severer features of zoster, or the zoster may be so mild that its manifestations partake of the benign nature of the simpler disease, in either of which cases some difficulty may be experienced in determining the true nature of the disorder.

Erysipelas usually begins with a marked rise in temperature. The affected area, although abruptly outlined, increases by peripheral extension, is edematous, and may or may not be covered with vesicles or bullæ which are not grouped. The color is an intense peculiar bluish hue, while zoster is a rosy pink.

With *eczema* zoster need never be confounded. The vesicles are wholly unlike. Those of *eczema* are small, thickly and irregularly scattered over the surface, and they rupture readily, while a continuous flow of serum follows their dissolution.

Zoster has been noted coincidental with *chicken-pox*. The pain, grouping of vesicles, and unilateral distri-

bution should differentiate zoster. Although there may be some scattered, isolated vesicles over the body, these would cover some nerve-area; there would be a group of vesicles on an erythematous base not seen in *varicella*. If coincidental, the zoster rash would not be influenced by the chicken-pox.

Zoster is not uncommonly seen in *psoriasis*. The rashes are so entirely different a tyro could differentiate the two. It is probable that arsenic, so often given for *psoriasis*, is the cause of the zoster.

ETIOLOGY.—According to Stelwagon, herpes zoster constitutes 1 to 1.5 per cent. of all skin diseases.

Many causes have been suggested as factors in the production of the disease. Age nor sex seems to have any particular influence, neither does occupation or nationality. It occurs in either sex, but there may be a preponderance in the male. The greatest frequency is between the ages of 8 and 20 years. It is not uncommon over 40; Lomer and Knowles each reports cases in infants of 4 days.

In general, there is thought to be some seasonal influence, with the greatest frequency in the spring, late fall, and winter. Atmospheric conditions appear to modify this for unknown causes, although Schamberg's experience does not indicate any special tendency. He cites 156 cases observed at the Polyclinic Hospital as follows:—

Winter (Jan., Feb., March)	40 cases.
Spring (April, May, June)	35 cases.
Summer (July, Aug., Sept.)	42 cases.
Fall (Oct., Nov., Dec.)	39 cases.

Cases have occurred following sudden change of surface temperature

of the body; after traumata, as the prick of a thorn (Janin), abscess incision, gunshot wounds; after the administration of some drugs, particularly arsenic—a marked example of which is shown in the noted epidemic in England, due to beer which was found to contain arsenic. Mental exhaustion, overwork, and excessive physical exertion are said to precipitate attacks.

Schamberg believes that when the disease is not traumatic it is probably an infective process due to the action of toxins developed from various sources. It has followed in the wake of pneumonia, influenza, measles, malaria, and epidemic cerebrospinal meningitis. Head considers it an acute posterior poliomyelitis.

Epidemics have been recorded, and there are undoubted cases of infection. One of the most remarkable was recorded by Walther and quoted by Duhring.

There is a close etiological relationship between herpes zoster and chicken-pox. The writer has collected about 50 cases in which these diseases occurred in close association. In the author's 7 cases an attack of zoster was followed in from 12 to 20 days by chicken-pox in a child in the family. Le Feuvre (*Brit. Jour. Dermat.*, Oct.-Dec., 1917).

The writers observed 3 cases of chicken-pox in adults, each of which was preceded and accompanied by typical herpes zoster. Goldberg and Francis (*Jour. Amer. Med. Assoc.*, Apr. 13, 1918).

Herpes zoster in a household is often followed by a case of chicken-pox. Chicken-pox may be followed by herpes zoster in the same house. Herpes zoster, in addition to the ordinary lesions, may show an eruption similar to chicken-pox. R. C. Low (*Brit. Med. Jour.*, July 25, 1919).

PATHOLOGY. — Barenprung demonstrated that the disease was primarily one of the ganglionic system, and this has been confirmed by numerous other investigators. Wyss examined a case dead of zoster facialis, and found the ganglion of Gasser enlarged, soft, and deeply injected. The nerve between the brain and ganglion was surrounded by extravasated blood. It was healthy at its origin. The peripheral filaments were infiltrated with soft tissue.

In a case in which the first branch of the trigeminus and the nasociliary branch were the nerves attacked, the interstitial tissue of the Gasserian ganglion, at the necropsy, was found infiltrated with inflammatory products and the ganglion cells destroyed. The ciliary nerves were likewise affected. Danielsen reports the intercostal nerve reddened and thickened and the neurilemma markedly infiltrated in a case of zoster of the trunk.

Later studies have confirmed the statements of these older observers, but they have also added much to our knowledge.

Head and Campbell undertook the study of zoster largely to "define the central representation of the affected area of the skin." The skin terminus was outlined by the site of the eruption. The central station was determined through Marchi's osmic acid method, and the findings disclosed were small hemorrhages into the posterior ganglion in the most acute cases; these were surrounded by leucocytic infiltration. The ganglion cells were destroyed in part, and in the older cases parts of the ganglion were much sclerosed. The secondary changes disclosed some degeneration of the peripheral afferent nerves; also,

degeneration of the posterior roots and the same process could be traced by the same method in some instances up the posterior column of the cord. The studies were made on 21 necropsies, varying from a few days to one and a half years after the eruption. In the case of zoster following blows and injuries to the skin, only the terminations of the nerves appear to be affected.

A vaccine administered for chorea was followed by herpes zoster. Greeley (*Jour. A. M. A.*, Dec. 2, 1916).

Association of zoster with alveolar and tonsillar disease suggests that zoster arises from focal infection. Lain (*Jour. Cutan. Dis.*, Aug., 1917).

The skin lesions of zoster have received much attention. Biesiadecki and Haight were the first who made a careful study of the vesicle. They found that it began in the deeper layers of the rete and that the exudation forcing its way upward separated the rete-cells, forming elongated bands or threads. After reaching the horny layer the fluid—no longer able to make its way between the cells—lifted the epidermal layer bodily, thus forming the roof-wall.

Robinson's investigations led him to the discovery of a perineuritis of the cutaneous nerves exhibiting a small-celled infiltration of the neurilemma.

Fine nerve twigs in the deep layer of corium show, according to Head, definite swelling of the neurilemma; the myelinated sheath is degenerated; the axis-cylinders show moniliform swellings. Large branches show marked degenerative changes (Marchi's method) ten days after the onset of the eruption.

Unna found that the vesicles in herpes zoster had a structure dis-

tinctively their own, due to a peculiar form of epithelial degeneration to which he applied the term "ballooning." In the process of colliquation that here takes place, the cells increase greatly in size, becoming, in many instances, hollow spheres, and in others with one side drawn out, suggestive of a balloon. Other unique and various forms are assumed. The protoplasmic contents are converted into a fibrinous, opaque mass, the nucleus is divided into a number of daughter-bodies that do not wholly lose their nuclear character, and the prickles are lost, thus severing the union of the cells the one with the other. In this disorganized condition the cells separate and accumulate in the hollow of the vesicle.

From the roof-wall of the lesion are seen hanging a number of compressed, cord-like, epithelial cells, forming a species of partition, thus dividing the cavity apparently into a series of compartments. But because of the indifferent connection possible in the cells undergoing this form of degeneration there is no real division of the vesicle. The vesicle contents, in addition to the degenerated epithelia and giant cells, consists of coagulated fibrin. Into the base of the vesicle can usually be seen projecting the denuded summits of the papillæ. The vesicle is situated well within the epithelial tissues.

When the acme of vesicle formation is reached, marked emigration of leucocytes from the neighboring vessels into the papillary body and the vesicle takes place. It seems, however, never sufficient to fill the cavity of the blister, crusting and desiccation occurring before this condition is reached.

What appears peculiarly striking is the relatively unimportant changes that take place in the epidermis around and beneath the vesicles. The blood-vessels and lymph-spaces are dilated for but a few lines only. The sweat-glands are not affected. The hair follicles share in the process, inasmuch as the prickle-cell layer dips downward toward their base. The cutis is involved in a slight degree only and that mainly by the infiltration of a few leucocytes.

Pfeiffer was the first to call attention to some peculiar bodies in the vesicles of herpes zoster.

PROGNOSIS.—Herpes zoster runs its course usually in from three to six weeks. Abortive types may end in ten days or less, while the severer forms may be much prolonged. The disease is rarely fatal, save when the ophthalmic region is attacked. A lethal issue is then possible, and the eye may be sacrificed even if life be spared. Scarring is a not infrequent sequel of zoster if the vesicles be broken. The cicatrices are gathered in clusters typical of the grouping of the disease, and each has an angular outline with precipitous edges that gives to it a distinct and unmistakable individuality. Long continuance of the neuralgia may vex and weaken the nervous system until the subject becomes a complete physical and mental wreck. Such cases are, however, exceptional. Its increased severity is, no doubt, due to the greater involvement of nerve ganglia, but the gravity that once was supposed to attach to the trouble has been disproved.

Herpes zoster recurs so seldom that one attack is believed to render the patient immune.

TREATMENT.—Herpes zoster is a self-limited disease, rarely endangering life, and seldom recurring. Its treatment is, therefore, simple. The most urgent indication with which we have to contend is relief of the pain. This is sometimes nearly unbearable. The character of the distress is likened often by the patient to that of a red-hot iron drilling into the flesh. Sleep then is impossible, and the restlessness is extreme.

The affected patient should be put to **bed** and absolute **quiet** enjoined. **Freedom from worry and care**, coupled with **complete physical relaxation**, is essential to the best results to be obtained from treatment. The bowels should be moved freely. For this purpose a mild dose of **calomel** given at bedtime, followed by a brisk **saline cathartic** in the morning, answers well. To keep the bowels open, a glass of warm **Hunyadi water**, or a **Seidlitz powder**, may be given each day before breakfast.

The **diet** should be light and easily digestible. Milk freely if the patient can tolerate it; broths, soups, soft-boiled eggs, oysters in season, fish, and chicken should constitute the list from which the articles of food for the patient's need may be selected. These patients often have very good appetites, and care should be exercised in not allowing overindulgence, such a course usually being followed by marked aggravation of the pain.

Internal medication has not as yet shown itself capable of shortening the course of the disease. But there are a number of drugs that markedly affect the pain and make the patient's condition bearable. Chief among these is **zinc phosphide**. This may be given in doses of $\frac{1}{6}$ to $\frac{1}{3}$ grain (0.01

to 0.02 Gm.) in tablet form every two or three hours until the pain is under control, when the dose may be reduced. It is sometimes more effectual when combined with the extract of **nux vomica**, $\frac{1}{8}$ to $\frac{1}{4}$ grain (0.008 to 0.016 Gm.) of the latter drug being used. **Sodium salicylate** and **salicin** in 10-grain (0.6 Gm.) doses every four hours, especially if there be any rheumatic taint, are often productive of much good. **Antipyrin**, **phenacetin**, and other drugs of the series relieve the pain, and it is thought have even shortened the course of the disease (Jennings). **Arsenic** is often used, but we should not forget that it is capable of producing the affection, and therefore likely to aggravate, instead of benefiting, the disorder. When employed it should be used in full doses, $\frac{1}{20}$ grain (0.003 Gm.) of **arsenous acid** in tablet form, or combined in a capsule with a small amount of **iron**, being given four times a day. Or, 3 to 5 minims (0.18 to 0.3 c.c.) of **Fowler's solution** in water after taking food may be used. **Quinine** in full doses is serviceable when malarial poisoning is the basis of the trouble. **Camphor** in small doses, often repeated, has been found to give the patient comfort.

If there be much nervousness, the **bromides of sodium and potassium** may be needed, but it is best to do without these drugs if possible. Tincture of **aconite** in drop doses at intervals of two hours has proved serviceable. **Sodium hyposulphite** in 5-grain (0.3 Gm.) doses every three hours does good.

It will be seen that the list of drugs employed is a long one, which being rightly interpreted means that no one of them is infallible, but that all will

fail at times to produce the results expected. If we cannot control the pain by drugs given by the mouth we may resort to hypodermic injections. Ten minims (0.6 c.c.) of **chloroform** will usually be sufficient to check the pain. **Cocaine** may also be used, but it is best to avoid this drug internally, owing to the danger of inaugurating the habit. **Morphine sulphate** given subcutaneously in from $\frac{1}{4}$ - to $\frac{1}{2}$ - grain (0.016 to 0.12 Gm.) doses will always control the pain. It is well to combine this drug with the **sulphate of atropine**, using $\frac{1}{100}$ to $\frac{1}{60}$ grain (0.00065 to 0.001 Gm.) of the latter.

External treatment should not be neglected. The vesicles should be preserved intact if possible. Opening them will not shorten the course of the disease nor mitigate the distress in any particular, and it nearly always results in the production of an obstinate ulcer that leaves an ugly scar. No picking or rubbing of the lesions should be permitted, and all sources of irritation—especially harsh woolen underclothing—should be removed. Dressings that protect the lesions from the air should be employed.

The following preparation will give relief, applied locally by dusting on the skin and then covering with cotton:—

R *Morphine sulphate* gr. xx (1.3 Gm.).
Sodium bicarbonate,
Prepared chalk,
Talc .. of each 3ij (12 Gm.).

Another application consists of 20 grains ($1\frac{1}{3}$ Gm.) of **morphine**, or a dram (4 Gm.) of **iodoform**, in an ounce (30 c.c.) of collodion; this is painted over the part till a protective film forms. Sometimes it will be

found that an ointment is the preferable form of application, as where the vesicles have deepened to ulcers. Then the following is efficient in pain-relieving power:—

R *Cocaine muriate*. gr. xx (1.3 Gm.).

Zinc stearate

compound ... ʒiiss (6 Gm.).

Rose water

ointment ʒj (30 c.c.).

Mix, and apply once or twice daily on layer of gauze.

Editorial (Med. World, Jan., 1909).

One of the best applications that can be used is **alcohol**.

It should be used in full strength, 94 per cent., and at frequent intervals. Compresses of cotton or soft-linen stuff should be saturated with the alcohol and bound over the parts. To prevent evaporation, these should be covered with some impermeable material, such as oil-silk or gutta-percha. This gives prompt relief to the burning and local distress, and affords the patient much comfort.

Ointments and pastes can often be used to advantage. **Lassar's paste** (see **HERPES SIMPLEX**) is useful. When properly made it furnishes a good protective dressing. It should be thickly applied and then thoroughly dusted over with a simple powder, such as **talc** or **cornstarch**. Anodyne remedies—such as **opium**, **belladonna**, or **cocaine**—may be added to it if needed. It is capable of relieving the cutaneous symptoms, and under it the lesions dry up and heal without rupturing. Simple ointments may relieve the itching and burning, but their softening influence upon the epidermis renders the rupture of the vesicle more probable.

Lime-water, **black-wash**, **carron-oil**, and **lead-water** washes may be found useful. They should be applied freely,

the surface being kept constantly moist with gauze saturated with the agent chosen. **Lotions of carbolic acid** and **camphor**, $\frac{1}{4}$ to $\frac{1}{2}$ dram (1 to 2 Gm.) of each to the ounce (30 c.c.) of alcohol, are valuable. The following substances in alcoholic or aqueous solution are often found useful: **Tannin**, 30 to 60 grains (2 to 4 Gm.) to the ounce; **menthol**, 5 to 15 grains (0.3 to 1 Gm.) to the ounce; **benzoin tincture**, 30 minims (1.8 c.c.) to the ounce; **resorcin**, 5 to 15 grains (0.3 to 1 Gm.) to the ounce. These should be applied freely to the affected parts and allowed to dry, after which a dusting-powder may be used with advantage. Such may be made of **zinc oxide**, **starch**, **boric acid**, **lycopodium**, or **talc**. **Anderson's dusting-powder**—which is compounded of camphor (1), zinc oxide (3), and starch (12)—is especially useful.

Where tenderness can be detected over the exit or in the course of a spinal nerve the **wet cup** may be tried. Not more than 1 ounce (30 c.c.) of blood should be abstracted. Or, a **blister** may be applied. For this purpose **cantharidal collodion** answers an admirable purpose, and frequently gives marked relief.

Duhring speaks very highly of the use of the **constant current** in the treatment of zoster. Its use wherever possible is to be commended. From 5 to 10 cells of the ordinary zinc carbon battery should be used. The negative pole should be placed over the seat of the eruption and the positive grasped in the patient's hand; or, better still, be passed up and down the spinal column. The belief exists that if used early enough it will abort or greatly shorten the course of the disease. Certain it is that it will

greatly subdue or soften the pains of the disorder. It is of the greatest value in the lingering pains that remain after the zoster has subsided. In such cases the current should be used two or three times daily, fifteen minutes being given to each application.

The introduction of **quinine sulphate** into the affected region by the **electric current** gives excellent results in the relief of pain. The part is treated with from 1 to 20 milliamperes passed through an electrode saturated with a solution of sulphate of quinine. The positive pole is used and the treatment varies from three to twenty minutes in duration. The method has been applied to the eye in some cases in which the herpes involved this organ, and the results were excellent. A. Macnab (Lancet, March 22, 1913).

HERPES (*Herpes Febrilis*).

DEFINITION.—Herpes simplex is an acute, non-contagious, benign disease of the skin, usually dependent upon a neuritis of the nerves supplying the part, and characterized by an eruption of vesicles in groups upon an inflamed, edematous base.

Herpes simplex may attack any part of the body-surface, but the malady shows a decided preference for two localities. These parts are the facial and genital regions. Because of the usual distinct restrictions of the disease to one or the other of these sites, and the diversity in symptoms that is liable to be manifested, two varieties of the disorder have been distinguished, and to each has been given a separate title. They are called *herpes facialis* and *herpes genitalis*. While essentially the same in nature, the specific causes apt to produce them, the dissimilarity of their manifestations, and the various dis-

eases with which they are likely to be confounded make their individual description a matter of necessity.

Herpes simplex appears but rarely in other situations upon the body and still less likely is it to occur in a generalized form. When such does happen, the term "*herpes generalis*" is applicable.

Among 246 cases of malaria, 121 had herpes and 98 developed it after each attack. It recurred invariably at the same point, usually the lips, but 3 times on the ear, 5 times on the tongue, etc. Garin and Descos (Prog. méd., July 14, 1917).

SYMPTOMS.—Herpes facialis may occur upon any part of the face or forehead.

The vermilion borders of the lips—also of the nose, upper lip, cheeks, and auricles—are favorite sites for its appearance. The mucous membranes of the mouth and throat are often implicated. So, too, the disorder may attack the cornea.

At the outset a slight tingling or burning is felt in the parts about to be attacked. Redness and swelling rapidly follow, and upon this edematous base a cluster of tiny vesicles soon appears. Usually an areola surrounds the group. The groups vary in number from one to a half-dozen or more, and in size from the surface of a split pea to a silver twenty-five-cent piece. They are round, oval, or irregular in outline, and may be closely set or widely separated. The vesicles are from pinhead to a kernel of wheat or larger in size and number three to a dozen or more in each group. They are fairly firm to the touch and do not readily rupture. Most authors describe a preceding papular stage. This is exceedingly

hard to demonstrate, and, if it does exist, is of very short duration. With care in the examination, fluid may be found in the lesions at the moment of their inception.

At the outset each vesicle is filled with clear, transparent serum. This gradually grows turbid, until by the end of the second or third day, if the lesion be not sooner ruptured, the liquid assumes a milky condition, and examination under the microscope shows an abundance of pus cells and degenerated epithelium. Where closely set the vesicles may coalesce, forming a flat-topped bleb.

Unless interfered with, the vesicles run their course in from four to ten days, the process then being completed by the formation of a crust, which desiccates and falls, leaving a brownish, pigmented spot. This pigmentation gradually disappears without forming a scar or other relic of the disease.

If the vesicle, as usually happens, is broken by picking, rubbing, or scratching, an excoriation results, which, if it does not become infected, is shortly covered with a crust, and the disease then runs its usual course and terminates in the ordinary way. Such crusts are dry and firmly attached. When the excoriations become infected with pus cocci or are treated with strong caustics, grave ulcers are apt to supervene and disfiguring scars remain.

Hemorrhage into the vesicle (black herpes) and gangrene sometimes complicate the process.

Subjective sensations are usually slight. The unsightliness of the disease causes the patient more distress than does the pain of the disorder. The tickling, burning, or prickling

sensations occurring at the outset may continue for a day or two and then subside, no further distress being experienced. Sometimes, though rarely, more or less itching is complained of, and even pain is occasionally felt.

Herpes of the mouth and throat (canker spots) presents a somewhat different appearance. Owing to the moist, warm condition of the parts the vesicles cannot develop as such. A round or oval patch, slightly elevated, and covered with a whitish, sodden exudate, is first formed. These spots may be situated upon the upper or under surface of the tongue, the border of the gums, the inner wall of the cheek, the palate, or the tonsil.

Herpes of the mouth, while not always severe, usually occasions considerable distress.

A condition that is known as "herpetic fever" is occasionally met with. The disease usually occurs in epidemics and is characterized by languor, vomiting, and chilly sensations, followed by a rigor and then a sudden attack of fever. The temperature may reach 104° F. (40° C.); the tongue is moist and heavily coated; the throat is sore, and the glands of the neck enlarged. Restlessness and delirium are exhibited at night. On the second day the vesicles appear and are usually confined to the face. Crocker speaks of defervescence being associated in some cases with the herpetic outbreak.

The disease runs its course in about four days, terminating in recovery.

The course of the disease and its occurrence in epidemics point to an infectious origin. Cases have been traced to sewer gas and faulty hygiene.

DIAGNOSIS.—Herpes facialis is to be distinguished from *eczema* by the larger size and greater stability of the vesicles, by their peculiar grouping, the insignificant sensations accompanying the disease, and the rapidity with which the disorder runs its course. There is no weeping, as in *eczema*, and no successive new formation of vesicles upon the same sites. The resemblance of herpes, when the lesions have broken and crusts have formed, to *impetigo* is sometimes marked. But in *impetigo* the crusts have been preceded by a single vesicle, bleb, or pustule. Instead of a group of vesicles, the patches of disease are not distributed in the line of any cutaneous nerve, but are scattered irregularly over the surface, and typical lesions can usually be found upon the hands and also upon the trunk. There is often a history of contagion. Care must be exercised in not confounding herpetic lesions of the mouth with the *mucous patches of syphilis*. Many patients, frightened by the knowledge of their exposure to syphilitic infection, point to their frequently recurring canker spots as indubitable proof that they possess the disease. More decisive evidence in the form of scars, alopecia, gummata, or the peculiar eruptions of syphilis must be searched for and found before confirmation of the subject's fears should be given. Veterans of syphilis are sometimes subject to herpetic troubles of the mouth that give rise to much mental distress on the part of the patient, but which are not in any wise related to the precedent lues.

Herpes simplex can be distinguished from *herpes zoster* by the bilateral distribution of its lesions, the

presence of fever, and the lack of nerve pain.

HERPES FACIALIS (FEVER-BLISTERS).

ETIOLOGY.—Herpes facialis is a common, though not necessary, accompaniment of many fevers and of catarrhal disorders of the nose, throat, bronchial passages, and lungs. The popular designation "cold sore" is indicative of the frequency with which the complaint occurs in simple coryza. Typhoid and intermittent fevers frequently give rise to it. Herpes simplex is very apt to occur in pneumonia not only upon the face, but upon the genitals and at times in other localities upon the body. At one time it was believed to occur regularly at the crisis in all cases of sthenic pneumonia in which a favorable outcome was likely to occur. Such auspicious prognosis, however, can no longer be maintained.

Although herpes febrilis commonly affects areas where skin joins mucous membrane, cases are sometimes seen in which the eruption is situated on parts of the skin at some distance from mucous membrane, and most works on skin diseases mention the fact that recurrent febrile herpes may appear upon the cheeks, the neck, or the buttocks, often recurring again and again in the same spot. Crocker quotes a case of Barthélemy of an "old woman dying of pneumonia, in whom some patches on the chest, with very large vesicles, were referable to herpes febrilis rather than to zoster." The writer has been unable to find any reference to cases of febrile herpes attacking the fingers, and thinks that the following examples are of sufficient interest to be recorded.

CASE 1.—A boy who, until 5 years of age, was in the habit of sucking his thumb, had periodical attacks of

an eruption of a group of three or four pinhead-sized vesicles on the end of the thumb. These eruptions were at first put down to the irritation of sucking, but after a time it was found that they coincided with the onset of an ordinary cold, and that a similar eruption sometimes appeared on the forefinger, which was not sucked. Once or twice the eruption on the thumb and forefinger was associated with ordinary herpes febrilis of the lip.

CASE 2.—A boy aged 4 years, a photograph of whose finger is here reproduced, presented a group of herpetic vesicles on the dorsal surface of the second joint of the left index finger. He had been fretful and poorly for some days. There was a single vesicle at the junction of the mucous membrane of the lower lip with the skin. There was no history of previous attacks.

CASE 3.—A girl aged 8 years, suffering from acute apical pneumonia, presented a group of vesicles upon the dorsal surface of the index finger of the right hand.

CASE 4.—A girl aged 9 years showed a group of seven or eight herpetiform vesicles on the dorsal surface of the fold between the roots of the first and second fingers of the left hand. She gave a history of repeated eruptions in the same situation. H. G. Adamson (Brit. Jour. of Dermat., Oct., 1909).

Disturbances of the digestive tract, especially in children, are prone to produce herpes of the lips. Indigestion, gastritis, gastric ulcer, and enteritis in adults are frequently associated with this form of herpes. It is not unusual in malaria, but is said to be rare in relapsing fever. Herpes of the nose and lips often coexists with tonsillitis and bronchitis.

Some persons are so extremely susceptible to the disease that merely brushing the face or the lips with a feather will induce it. Many women

are affected at each menstrual epoch with labial herpes.

Toothache as well as dental instrumentation is known to produce the trouble.

Blows upon the head, exposure of the face to alternate hot and cold blasts, or the application of irritating medicaments to the parts are fruitful sources of the disorder. Many cases are thought to arise without appreciable cause, and are spoken of as idiopathic, but it is doubtful if such is ever strictly the truth. A careful analysis would, in all likelihood, re-



Case. 2.—Herpes febrilis. (Adamson.)
(British Journal of Dermatology.)

veal in each instance the existence of some irritating factor capable of producing the affection.

PATHOLOGY. — Owing to the benign nature of the disease, opportunities for studying its pathology are rare, and our knowledge is correspondingly limited.

There is good evidence to believe that *ophthalmic herpes* is dependent upon definite lesions in the Gasserian ganglion, which is morphologically a dorsal-root ganglion. The frequency of a febrile onset is striking, and though herpes febrilis does not manifest the same accuracy of distribution, according to nerve supply that is found in herpes zoster, it is yet probable that the causal lesion should be referred to the peripheral sensory nerves and most likely to

their ganglia rather than to their terminations. *Herpes zoster* is the outcome of an intense and concentrated attack upon certain dorsal-root ganglia. *Herpes febrilis* and the paralytic affections of the cornea (and possibly of other parts of the body) may reasonably be regarded as a less acute, more widely diffused attack of a similar nature. In herpes zoster parts only of an individual ganglion are likely to be destroyed. In the paralytic forms we must predicate less destruction of tissue and abolition of function, but finer localization, often combined with wider diffusion, of partial derangement of tissue and disorder rather than demolition of function. Neuroparalytic keratitis is due to irritation of the distal end of the cut or diseased trigeminal nerve. Parsons (Lancet, May 25, 1907).

Unna found that the process originated in the upper layer of the rete mucosum and was a true coagulation necrosis. The cells affected were much enlarged and the cell contents were greatly changed. The nucleus had disappeared and the protoplasm could not be stained. This was due to saturation of the cell with fibrinogenous substance from the fluid surrounding the cell-body. The cell retained its normal shape and the prickles remained intact. Beneath the zone of necrotic tissue a layer of flattened and thinned prickle cells was found that still retained its normal features and the cells their capacity for staining, thus indicating that the elevation of the whole epithelium was a secondary, and not a primary, occurrence. Deeper down in the rete were cells in a necrotic condition. In most of these the nucleus had disappeared, leaving only a cavity, while, in some, cell substance had been completely dissolved in the fluid of the

blister. The heads of many papillæ projected into the cavity of the lesion and were entirely denuded of epithelium. It would appear, then, that the process consists of two distinct steps, the first consisting of a fibrinous inflammation of the upper prickle-cell layer, converting it into a nuclear, degenerated, necrotic mass, forming later the roof-wall of the vesicle. The second, the loosening of the epidermis as a whole, with the formation of a subepithelial blister, whose contents again undergo coagulation necrosis. The blood-vessels and lymph-spaces underneath and about the lesion were found markedly dilated, and distinct, though not extensive, migration of leucocytes was evident.

The pathology underlying herpetic inflammations of the geniculate ganglion is the specific hemorrhagic inflammation of the ganglion as found in zona. As the geniculate is lodged in a narrow bony canal and stands in close relation to the seventh and eighth nerves, the characteristic syndrome is produced, which may be divided into three clinical groups: (1) *Herpes zoster auricularis*; (2) *herpes zoster* in any of the zoster zones of the cephalic extremity (*herpes auricularis*, *herpes facialis*, and *herpes occipitocollaris*) with facial palsy, and (3) *herpes zoster* of the cephalic extremity with facial palsy and auditory symptoms (tinnitus, deafness, vertigo, vomiting, nystagmus, and disturbances of equilibrium). J. Ramsay Hunt (Jour. Nerv. and Mental Dis., Feb., 1907).

PROGNOSIS.—The disease is a benign disorder running its course, if not irritated, in from four to twelve days. No scarring is produced. Pigmentation follows the desiccation of the vesicles, but this soon disappears. The disease is exceedingly prone to

recur,—in many patients with almost periodical regularity.

TREATMENT.—The treatment of herpes of the face should be of the simplest kind. All irritation should be removed. No picking, scratching, or rubbing should be allowed. The smoker should be made to give up his pipe or cigar, and all forms of tobacco had best be interdicted.

Strong **acetic acid**, if applied at the outset before the vesicles have formed, will often cut short the attack or greatly lessen its severity. The action of the acid should be checked before whitening of the skin takes place. If the itching and burning are at all severe, lotions of dilute **lead-water** and **opium**, **zinc oxide** and **lime-water**, **elderflower-water**, **camphor-water**, or weak **ammonia-water** may be used freely. These should be followed by a simple dusting-powder, such as **starch**, **boric acid** and **talc** (1 to 8), **stearate of zinc**, or **lycopodium**. Painting the parts with **flexible colloidion** after the vesicles have fully formed makes an admirable dressing. Ointments, as a rule, are not well borne. The **Lassar paste** (**salicylic acid**, gr. v [0.3 Gm.]; **zinc oxide** and **talc**, of each, ʒij [8 Gm.]; **vaselin**, ʒiv [16 Gm.]) makes a good protective covering.

Internal medication for the relief of the disease while in its course is useless. As a prophylactic, according to Dühring, **arsenic** is of positive value, and will cure the tendency to the disorder. It should be given in full doses: $\frac{1}{20}$ grain (0.003 Gm.) of **arsenous acid** four times a day, or **Fowler's solution**, 3 to 7 minims (0.18 to 0.42 c.c.), after meals. **Cold sponging** of the body each day, especially of the spinal region, followed by **vigorous**

friction, will help to control the tendency.

The treatment of recurrent herpes is uncertain of results. In the case of recurrent herpes appearing on the face of a young woman or a girl the use of caustic applications should be avoided; in fact, it would be best to leave the affection entirely alone. The same applies to groups of vesicles filled with serous fluid. The simplest applications are indicated, as a lotion consisting of a hot **decoction of chamomile flowers** (about 5 flower heads to 1 pint of water) applied cautiously by means of sterilized cotton. At night the following ointment is to be used:—

R *Ichthyol* gr. xv (1 Gm.).

Zinc oxide ʒj (4 Gm.).

Simple cerate,

freshly prepared, free

from water ... ʒix (36 Gm.).

M.

During the day a slight application of **casein ointment** may be made, which is afterward lightly dusted with **talcum**. Pautrier (*Le Bull. méd.*, March 19, 1910).

In 19 cases out of 20, sufferers from recurring herpes of the tongue are syphilitic. While mercurial treatment would, in consequence, seem to be indicated, it only aggravates the condition when it is actually attempted. Irritating substances, such as alcohol, spices, mustard, and especially tobacco, are likewise harmful and should be forbidden. A bland **diet**, consisting of milk, vegetables, cooked fruit, and thoroughly cooked white meats, should be ordered. As for local treatment, emollients alone are indicated in the inflammatory stage. A **decoction of althea**, used as a tepid local wash, and alkaline solutions, such as **Vichy water** or a 0.5 or 1 per cent. solution of **sodium bicarbonate**, are particularly useful. As the inflammatory process subsides, mild astringents, such as a 1 or 2 per cent. **decoction of strawberry root**, may be employed, while during the

Intervals between attacks **gambir** is suitable.

Where ulceration is present, the writer applies **camphonaphthol** in minute quantities or uses Vidal's formula, which is as follows:—

℞ Powdered so-
dium borate.. 3iiss (10 Gm.).
Cherry-laurel
water 3vi¼ (25 Gm.).
Neutral glyc-
erin 3iv (15 Gm.).

M. et ft. lotio.

If there is marked pain, a 2 or 3 per cent. solution of **cocaine hydrochloride** should be painted over the lesions, more particularly before meals. The treatment should include the administration of **codliver oil**, **phosphorus-containing** preparations, and **sulphur baths** to patients of the lymphatic type, and of **alkaline preparations** internally and **bicarbonate baths** to those of the arthritic or lithemic type. In the latter, **colchicum** in small doses is useful. Plicque (Bull. méd., March 9, 1912).

In a case of recurrent generalized herpes simplex, the writer isolated a causative streptococcus, and cured the condition with an **autogenous vaccine**. Frank Cohen (Jour. Amer. Med. Assoc., May 20, 1916).

HERPES GENITALIS.

Besnier has lately given the appellation "genitalis" to all forms of genital herpes, and the term is much to be preferred to the older designations: "progenitalis" and "preputialis," neither of which were strictly accurate. A form known as "herpes gestationis," which occurs, as its name indicates, in parturients, is also recognized.

SYMPTOMS.—Burning and itching, with sometimes pain, precede the appearance of the vesicles. Usually there is but one group, but occasionally the number is greater. There are not apt to be as many vesicles in

each cluster as is the case in herpes of the face. A reddened edematous base with a single or at most two or three distinct vesicles upon it is not uncommon. Certain sites upon the genitals seem to be favored by the disease. These, in the order of their frequency in men, are the sulcus, the reflected mucous membrane of the prepuce, the glans, the margin of the prepuce, and the skin on the shaft (F. B. Greenough).

In women the sites of preference are the skin of the vulva, the inner border of the labia majora, any part of the labia minora, the prepuce, the clitoris, and the orifice of the urethra. When the lesions are situated upon the mucous membranes the vesicles rupture early and the patient first notices an excoriation, covered by a whitish deposit. Upon the integument of the vulva or penis the vesicles look like tiny droplets of water. They rapidly lose their clear, shining appearance, however, owing to the increasing turbidity of the contents. Crusting follows, and if the disease is not irritated the process terminates by the falling of the scab in from one to two weeks. A pigmented spot remains. This eventually disappears. There is no scar.

One of the triumphs of the theory and practice of serotherapy was the discovery but two years ago that a pregnancy serum is able to cure *herpes gestationis* outright. A similar advance in our knowledge of the gestation toxicosis is likewise secured, for we are now amply justified for this and other reasons in speaking of an autotoxic state dependent on pregnancy. As is well known to dermatologists, there are two closely related toxic dermatoses of gestation. One of these is very rare and malignant—the so-called impetigo herpeti-

formis. The other or benign type is the so-called herpes gestationis. The malignity of the first named is due to its progressive character and the impossibility of antagonizing it. Whether **serotherapy** can arrest this form we do not know, because its infrequent occurrence gives no chance to test the resource. The controllability of the milder form is complete. The itching, which is the most burdensome symptom, ceases promptly under the treatment. The latter is simplicity itself. **Blood-serum** is obtained from a healthy pregnant woman and 10 c.c. (2½ drams) are injected subcutaneously in the gluteal region. The serum was from a gravida at the ninth month. Veiel (Med. Rec., from Münch. med. Woch., Aug. 27, 1912).

Itching is apt to be severe, especially in women. Neuralgic pain, simulating that of zoster, is sometimes felt. These cases should be regarded with suspicion, but it is not a wise measure to call every attack of this nature *shingles*.

The lesions in the male are usually situated in the line of the dorsalis-penis nerve. When close set the vesicles may coalesce.

DIAGNOSIS.—The recognition of the disease does not usually present any great difficulty, but care is sometimes needed in arriving at correct conclusions. The mental distress of the patient is generally out of all proportion to the severity of the disorder, and this, coupled with the ease with which the lesions may be confounded with the initial sclerosis of *sypilis*, makes the subject a fruitful field for the quack and the unprincipled practitioner. Many a young man has had his life made bitter and has parted with his years of hard-earned wealth because some such scoundrel has pronounced the simple herpetic lesion

exhibited a virulent chancre. If the truth might be known, many of the wrecks behind the bars of our insane asylums could be traced to this cause. On the other hand, the ease with which syphilitic infection may take place at the site of the herpetic vesicle or excoriation will make the careful practitioner exceedingly guarded in his statements to his patient. He is a physician of very limited observation indeed who has not seen an undoubted case of genital herpes linger along, getting worse instead of better, until it had assumed the classical features of a chancre or chancroid, to be followed by the disastrous results of the one or the other.

If there be a history of exposure to a probable source of infection, sufficient time to exclude the possibility of such infection must be insisted upon before a final answer be given.

The Wassermann reaction, carefully performed, may be a deciding factor as to whether the patient has syphilis or not. Much time may be thus saved from waiting for sufficient symptoms to make a positive answer warranted. This, in the case of *chancroid*, need be but a few days. The pain, the intense inflammation, the formation of a true ulcer, and the development of the single inguinal bubo will tell the story.

If haste is imperatively necessary the autoinoculability of the secretion may be tried.

If true *chancre* be expected, at least six weeks from the time of the exposure should be allowed to elapse before a definite decision can be rendered. The sluggishness of the lesion, the induration, the double inguinal enlargements, and the characteristic eruption will distinguish it.

ETIOLOGY. — Herpes genitalis occurs in both sexes, but with relatively greater frequency in the male than in the female. In persons subject to the disorder any irritation of the genital regions is likely to induce an attack. Ungratified sexual excitement, local uncleanness, coitus, masturbation, friction with the underclothing, passage in the male of a sound, or pressure of the saddle on horseback or the bicycle are common and fruitful sources of the mischief. In some women it appears at each catamenial epoch, preceding, accompanying, or following the period. It is frequent during pregnancy. Venereal disorders, such as gonorrhea and chancroid, as has been so well shown by Doyon, are apt to induce it. They are not, however, as he endeavors to show, its invariable precursors. Vaginitis and leucorrhea are prone to give rise to the disease, the irritating discharges acting as the exciting factor. Fournier and Unna have shown that it is very common in prostitutes and lewd women. In women infected by their husbands with syphilis or gonorrhea it is said to be infrequent.

Herpes genitalis is a disease of early and middle adult life. It rarely occurs in infancy and seldom after 50 years of age. Like herpes of the face, it sometimes appears to arise without appreciable cause. Disorders of digestion and constipation are named as exciting factors, but it is doubtful if such be the case.

A redundant prepuce is unquestionably a predisposing element in men. Balanitis is sometimes regarded as a cause, but the probability is that it is due to the same derangements that induce the herpes.

PROGNOSIS. — Herpes genitalis is a disease that recurs with exasperating frequency and occasionally makes life a burden to its victim. But, aside from the tormenting pruritus and the belief in its venereal origin, it is seldom that it gives rise to much that can be characterized as more than mere annoyance. The patient's fears need to be allayed and faulty sexual habits and hygiene corrected. The tendency of the trouble is toward rapid healing. Where ulceration results from the improper use of caustics the process may be much prolonged and phimosis with distinct narrowing of the preputial orifice may result.

TREATMENT. — Caustics should never be used in the treatment of herpes of the genital organs. Grave ulceration is liable to result and the more important factor of accurate diagnosis is almost sure to be clouded. The simplest antiseptic washes with absolute cleanliness are sufficient. Immersing the parts, where possible, in a warm solution of boric acid, or bathing them with the same twice a day and dusting afterward with **europhen** or **aristol**, is all that is needed. Weak solutions of bichloride of mercury, zinc sulphate, or potassium permanganate may be used. Duhring speaks highly of the following formula:—

R *Zinci sulphatis*,
Potass. sulphidi,
 āā ʒj-3j (1.3-4 Gm.).
Spt. vini recti-
ficati 3j (4 c.c.).
Aquæ f3vij (28 c.c.).

M. Sig.: Shake and apply frequently and freely.

All sources of irritation should be removed. **Borated cotton** makes a good covering.

In dressing the penis no bandage should be used. It interferes with the return circulation and is liable to induce phimosis.

A preparation of **arsenic** may be tried as a prophylactic, and **cold sponging** of the body should be practised daily. In persistent cases the use of the **faradic current** daily over the **spine** may be tried.

In treating herpes zoster, the writer gives **Fowler's solution**, 6 minims (0.36 c.c.) 4 times daily. The parts are cleansed with 2 per cent. **creolin solution**, and freely dusted with **borated talcum powder**. Over this absorbent cotton is applied. L. H. Adler, Jr. (Penna. Med. Jour., Aug., 1916).

In patients with a long foreskin **circumcision** should be advised.

The writers outline the following treatment of this form of gestational autotoxemia: (1) **Rest** in bed. (2) **Absolute milk diet**. (3) The use of **laxatives** daily, or of **purgatives** every three days with **saline enemata** on the intervening days. (4) A **warm starch bath** lasting one-half hour every day or every other day. (5) The use twice a day of:—

R *Chloral hydrate* ... ʒiiss (10 Gm.).
Distilled water Oij (1000 c.c.).

After this, the application to the itching parts of a powder made up as follows:—

R *Salicylic acid* gr. xv (1 Gm.).
Powdered starch,
Powdered talc,
of each ʒxiiss (50 Gm.).
Zinc oxide ʒiiss (10 Gm.).

If the itching is intolerable, it may be necessary to administer **chloral hydrate** internally. In case the stomach does not tolerate this drug, it should be given *per rectum* in doses as high as 2 Gm. (30 grains), dissolved in boiled water or milk. Rudaux,

Grosse, and le Lorier (Théráp. obstét.; Med. Rec., Jan. 18, 1913).

In recurrent herpes in children, the writer advises that adenoids, dental trouble, defective eyesight, and intestinal worms, be remedied. Two to 5 grains (0.12 to 0.3 Gm.) of **quinine** at the beginning of an attack may abort it, as also **collodion** locally before the vesicles have matured, or **calamine lotion** if already formed. H. G. Adamson (Brit. Jour. of Child. Dis., July, 1916).

WM. FRANCIS ROBINSON,
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AND

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HETEROCHYLIA. See STOMACH, DISEASES OF.

HEXAMETHYLENAMINE (hexamethylenamina; hexamethylenetetramine; urotropin; cystogen; cystamine; aminoform; formine) is an organic substance made by passing dry ammonia gas into a solution of formaldehyde and having the chemical formula $(\text{CH}_2)_6\text{N}_4$.

Prepared first by Butlerow in 1860, hexamethylenamine was introduced into medicine by Nicolaier and Bardet, the former of whom recommended it for the purpose of preventing the deposition of urates. Soon after, its value as a urinary antiseptic became recognized, and it came into widespread use almost exclusively for this purpose until in 1908 Crowe and in 1910 Barton showed that it was eliminated also by other channels and its field of usefulness was thereafter extended.

Hexamethylenamine occurs as a white, crystalline powder which is odorless, tasteless, and freely soluble in water, though less soluble in alcohol and almost insoluble in ether.

PREPARATIONS AND DOSE.—

Hexamethylenamina is the name under which the drug is officially recognized. Various special appellations have also been given to the identical substance, most of which have been mentioned above. None of the unofficial preparations set free more formaldehyde than the chemically pure hexamethylenamine (Crowe). Helmitol, which is an allied but not identical preparation, is hexamethylenetetramine anhydromethylene citrate $[C_7H_6O_7 \cdot (CH_2)_6N_4]$ and has properties similar to those of the official compound.

The single dose of hexamethylenamine ranges from 5 to 60 grains (0.3 to 4 Gm.), the average amount for purposes of genitourinary antiseptics being 10 grains (0.6 Gm.). The larger doses have been used chiefly to exert an antiseptic effect in the cerebrospinal fluid or other body humors into which the drug is excreted only in small amount.

The dose of hexamethylenamine *per diem* has been carried by Crowe as high as 200 to 300 grains (13 to 20 Gm.), the drug being administered in part by rectum, without untoward effect. In many cases, however, the giving of 75 grains (5 Gm.) a day for ten days was found to bring on symptoms of irritation of the urinary tract. For ordinary purposes, 8 to 15 grains (0.5 to 1 Gm.) of the drug three times a day can be considered sufficient in many instances, and safe almost invariably, though in the notable proportion of cases which fail to split off formaldehyde easily from the hexamethylenamine larger amounts can be given without risk.

MODES OF ADMINISTRATION.—Hexamethylenamine should

always be given well diluted with water, even when used in small doses, as the likelihood of an irritant action on the urinary tract is thereby rendered much less. According to Crowe, doses of 10 or 15 grains (0.6 to 1 Gm.) should always be dissolved in 250 or 300 c.c. (8 or 10 ounces) of water. The same observer, where large amounts of the drug are to be administered, gives it in the dose of 1 to 3 grains (0.06 to 0.2 Gm.) in every ounce (30 c.c.) of water or liquid food—milk or broth—the patient takes, and finds it often possible thus to give from 60 to 100 grains (4 to 6½ Gm.) a day without the patient's knowledge and without untoward phenomena.

Where the patient is very ill, Crowe usually administers the drug by rectum, from 50 to 100 grains (3.25 to 6.5 Gm.) being dissolved in a quart (liter) of salt solution and allowed slowly to flow into the bowel, drop by drop.

When hexamethylenamine is given the urine should be tested for formaldehyde, and ascending doses given until this substance appears or until evidences of vesical irritation develop. The point is to give the largest dose possible without developing bladder irritation. Burnam (*Archives of Intern. Med.*, Oct., 1912).

CONTRAINDICATIONS.—In the presence of acute nephritis the possible irritant effect of hexamethylenamine renders it advisable either to greatly reduce the dose given or omit the drug altogether.

In hematogenous infections of the kidney the effects of hexamethylenamine are uncertain and capricious, and the drug may cause irritation of the urinary tract, which will have the effect of keeping up the inflammation. Phenyl salicylate, 4 cachets of 15

grains (1 Gm.) each daily,—with copious drinking of distilled water, permanent catheterization, and autogenous vaccine treatment,—is to be preferred. Rovsing (Rev. clin. d'urol., Nov., 1913).

In some individuals hexamethylenamine tends to call forth or aggravate headache. A relative contraindication to the drug is here afforded.

The writer has tabloids made up coated with keratin, in which form the drug does not split in the stomach and cause gastric symptoms. The urine must be kept in an acid state with either acid sodium phosphate or ammonium benzoate. In acute colon bacillus infection he recommends alkaline treatment of the urinary tract before resorting to hexamethylenamine, which should then be given to the limit of tolerance, whether the kidney or the bladder is involved. J. W. T. Walker (Med. Press and Circ., ci, 304, 1916).

PHYSIOLOGICAL ACTION.

—**Externally**, hexamethylenamine is a rather inert substance. Micro-organisms exposed to it in 5 to 10 per cent. solutions were found by Burnam entirely to escape injury. Nicolaier had already found, however, that the drug acted on bacterial cultures at body temperature, and concluded that it exerted an antiseptic effect owing to the liberation from it of formaldehyde. This is now the established view of the mode of action of hexamethylenamine, and readily accounts for the lack of effect evident *in vitro* in the cold. Burnam found the drug unirritating and used it in the bladder and kidney in a 50 per cent. solution without either any ill result or any appreciable effect on the infection present.

Heating hexamethylenamine enhances its disinfecting power. At 37° C. a 0.5 per cent. solution has as

powerful a sterilizing action as a 2 per cent. solution at 17° C. The presence of albumin does not interfere with its action. Test-tube experiments showed that minute amounts of the drug added to sputum arrest its putrefaction. Zak (Wiener klin. Woch., Jan. 25, 1912).

Internally, hexamethylenamine, upon entering the blood, is believed to remain unchanged. It begins very promptly to be eliminated in the urine, but meanwhile it circulates widely in the body, and enters the bile, cerebrospinal fluid, saliva, milk, as well as other secretions, at least in small amounts. Crowe found it in synovia and the fluid of a pleural effusion, while Barton and others concluded from their clinical experiences that it must be eliminated by the mucous membranes of the middle ear, accessory nasal sinuses, and respiratory passages as a whole. The possibility that formaldehyde may be set free from hexamethylenamine in the various body fluids referred to, while generally recognized for a time, seems to have been disproved, excepting as regards the urine, by Hanzlik and Collins.

After administration by mouth, hexamethylenamine appears in the bile and pancreatic juice of dogs. It finds its way into the bile both through the liver and through the wall of the gall-bladder. When given to man in sufficiently large doses (75 grains—5 Gm.—per diem) it appears in the bile in quantities sufficient to exercise a decided bacterial action. S. J. Crowe (Johns Hopkins Hosp. Bull., April, 1908).

If a patient receives 10 or 15 grains (0.65 or 1 Gm.) of urotropin it can be found in a short time in cerebrospinal fluid obtained by puncture. The average time would seem to be from thirty minutes to one hour. The cerebrospinal fluid possesses under

these circumstances a germicidal power which the ordinary fluid does not. Crowe (Johns Hopkins Hosp. Bull., April, 1909).

Experiments indicating that hexamethylenamine is excreted unchanged in the saliva. The greatest amount of the drug seemed to be excreted during the first thirty minutes after its administration. No free formaldehyde was found. It is known that the liberation of formaldehyde is a very slow process. Stagnation of the urine, bile, or cerebrospinal fluid in the body would probably give time for this process to occur; but in the case of saliva there is no stagnation, and consequently it is rather improbable that any effective quantity of formaldehyde could ever be liberated. P. J. Hanzlik (Jour. Amer. Med. Assoc., June 11, 1910).

Even after rather large doses of hexamethylenamine, there appear in the bile, sputum, saliva, and cerebrospinal fluid only traces of the drug,—less than 1:150,000. It was also ascertained by the author that *in vitro* a 1:50,000 formaldehyde solution, and a 5 or 10 per cent. hexamethylenamine solution, are both incapable of destroying or inhibiting the growth of various micro-organisms, such as the streptococcus, staphylococcus, and typhoid bacillus. With these facts as basis, the author asserts that the use of hexamethylenamine for the curing or bettering of, or as a prophylactic against infections of the bile passages, respiratory passages, and cerebrospinal system is illusory. C. F. Burnam (Arch. of Int. Med., Oct., 1912).

The writer found granular casts, red cells, and massive albumin in a patient free of renal or cardiac disease, who had taken large amounts of hexamethylenamine for colon bacilluria. The formaldehyde may have permanently damaged the kidneys. Nine years later, however, his health was apparently normal. O. Leyton (Lancet, July 22, 1916).

Little information is available concerning the systemic effects of hexa-

methylenamine, which are, however, of but slight importance since such effects in man would in practically all cases be overshadowed by those of the formaldehyde set free. Experimental animals are very tolerant of the drug, rabbits, *e.g.*, withstanding a dose, given subcutaneously, equivalent to about 18 ounces in the human subject. In these animals the drug escapes in the urine wholly unaltered, no formaldehyde being ever set free. Observations such as these seem clearly to show that renal and vesical irritation following the use of hexamethylenamine in man is due not to the drug itself but to formaldehyde.

Report of experiments in which hexamethylenamine was dissolved in sterile water and injected subcutaneously in guinea-pigs. As a rule, $4\frac{1}{2}$ to 5 grains (0.29 to 0.32 Gm.) per ounce (30 Gm.) of body weight killed the pig, or rendered it very quiet for twelve to fourteen hours. If the dose proved fatal it usually did so within a few hours. If the animal survived twenty-four hours, it recovered. After a fatal dose the pigs grew more and more quiet, and in the course of two or more hours usually toppled over, had some slight twitching of the extremities, and gradually died. Others were found in a sitting position, which suggested that they grew more and more quiet and then died. In none were any convulsions noted. The pigs were able to withstand sublethal doses for a considerable period of time without any ill effects other than reaction at the point of injection and some quietness for a few hours after the injection. Crowe (Johns Hopkins Hosp. Bull., vol. xix, p. 109, 1908).

The localities at which the formaldehyde is set free in the system are believed to be the kidney and bladder. Fleig showed in oncometric experiments that primary vasoconstriction,

followed by vasodilation, is brought about in the kidney by hexamethylenamine. According to Fullerton, the drug possesses some diuretic action.

Elimination of hexamethylenamine in the urine upon its administration by mouth has been shown to begin in fifteen and even ten minutes. According to Burnam, the drug is excreted actively for eight hours, after which the amount passing out dwindles markedly until in twenty-four hours, even after a large dose, the drug can no longer be detected. As for the formaldehyde set free and eliminated in the urine, observations of the same author indicate that its amount and even its appearance at all depend in some measure upon the dose of hexamethylenamine taken. Individual variations are also a prominent factor, and there appears to be no certainty that, in a given person, formaldehyde will be excreted unless the dosage is progressively increased until this product can be actually detected through a chemical test.

The test recommended by Burnam for the detection of formaldehyde in the urine of patients taking hexamethylenamine is performed as follows: To about 10 c.c. of the urine in a test-tube at body temperature are successively added (1) 3 drops of a 0.5 per cent. solution of phenylhydrazine hydrochloride; (2) 3 drops of a 5 per cent. solution of sodium nitroprusside; (3) a few drops of a saturated solution of sodium hydroxide, poured along the side of the test-tube. If formaldehyde is present a deep purplish-black color is seen as the alkaline solution diffuses through the urine; this quickly changes to a dark green, gradually assumes a lighter shade of the same color, and

finally turns to pale yellow. Where formaldehyde is not present, on the other hand, a reddish color instead develops, gradually turning to light yellow.

Burnam test applied to the urine of over 250 patients taking hexamethylenamine by mouth. Only 130, or 52 per cent., showed the presence of formaldehyde. The reaction of the urine is of no importance. Alkalies taken with or in combination with hexamethylenamine have no effect on excretion. The duration of excretion of formaldehyde is about four to six hours. Increase of dosage does not affect excretion in negative urines. L'Esperance (Boston Med. and Surg. Jour., Oct. 24, 1912).

In doses of from 5 to 10 grains (0.3 to 0.6 Gm.), three times a day, not more than 2 patients out of 10 show any decomposition of the drug into formaldehyde. At least 60 per cent. show such decomposition, however, when from 20 to 30 grains (1.3 to 2 Gm.) are given every four to six hours. Clinically, it is the free formaldehyde which is the effective agent. Its liberation appears to be due to some specific activity of the renal epithelium. There is no fixed dose of hexamethylenamine. The only toxic effect is occasioned by the liberation of formaldehyde, and when this does not occur, it is safe to increase the dose until it appears. The proper treatment is to give a dose just sufficient to cause bladder irritation; improvement will then generally follow so rapidly that long-continued use of the drug will not be required. C. F. Burnam (Archives of Intern. Med., Oct., 1912).

It has been demonstrated that hexamethylenamine is more effective as a urinary antiseptic if the reaction of the urine is acid than where it is alkaline. Burnam found, indeed, that the greatest decompositions of hexamethylenamine into formaldehyde occurred in highly acid urines, but in

definitely alkaline urines he also occasionally met with large amounts of formaldehyde.

Hanzlik and Collins prefer the phloroglucin test for formaldehyde to that used by Burnam.

The phloroglucin test is the most delicate and useful test for free formaldehyde. The reagent used consists of phloroglucin (reagent, Merck), 0.1 Gm., dissolved in 10 c.c. of 10 to 20 per cent. sodium hydroxide. When first prepared the solution acquires a bluish-violet color, but on standing becomes entirely colorless or with at most a yellowish tinge. The reagent may be used freshly prepared, as the violet color does not interfere. The test is performed by the addition of about 0.5 c.c. of the reagent to about 1 to 2 c.c. of the fluid containing formaldehyde. A deep bright red appears instantaneously with higher concentrations of formaldehyde, but with lower concentrations it requires about one-half to one minute for the color to reach its maximum intensity. The color persists for at least five minutes with dilute solutions, and much longer with the concentrated formaldehyde solutions. The test is directly applicable to all body fluids except whole blood and bile. The reagent added to water alone gives a clear colorless solution.

Alkalies prevent, while acids facilitate, the liberation of formaldehyde from hexamethylenamine in all body fluids. Liberation of formaldehyde depends on the excess hydrogen ion concentration of the solution above the neutral point. Administration of monosodium phosphate with hexamethylenamine renders the urine acid and facilitates the liberation of formaldehyde. Administration of alkali inhibits the liberation of formaldehyde. The beneficial therapeutic effects of hexamethylenamine depend on the liberated formaldehyde. It is irrational to prescribe alkalies (bicarbonate and citrate) with hexamethylenamine. A urine previously alkaline can be rendered acid in about

five hours by the administration of 13 Gm. (200 grains) of monosodium phosphate. If the occurrence of diarrhea is objectionable, the dosage of the phosphate may be reduced. P. J. Hanzlik and R. J. Collins (Arch. of Intern. Med., Nov., 1913).

Formaldehyde is a weak and relatively slow germicide, but even in high dilutions exerts a powerful inhibitory influence on bacterial development. A dilution of 1:16,000 is totally inhibitory to *Bacillus typhosus* for twenty-four hours, and 1:6000 is completely germicidal at the end of that time. A dilution of 1:30,000 definitely restrains the growth of the organism, but a dilution of 1:40,000 has no apparent effect.

Of 23 urines obtained by catheterization of the ureters after hexamethylenamine administration, only 5 showed formaldehyde, and these had only a 1:60,000 of it. The 18 negative urines all gave a positive test for hexamethylenamine. The latter, as it is excreted from the alkaline blood, does not remain at the level of the kidney long enough to give good conversion, and even with high acidity and high concentration the formaldehyde at this level is seldom enough to furnish antiseptics.

Only 4 of the author's 116 cases, however, failed to show formaldehyde in the bladder, but only 8 cases, or about 7 per cent., revealed formaldehyde in the germicidal strength (1:7000) and 5 of these had been given acid sodium phosphate. Fifty-five per cent. of the cases gave at some one examination a 1:30,000 test or better.

A formaldehyde content of antiseptic value cannot be expected with a urinary acidity below 2 c.c. of tenth-normal sodium hydroxide for 10 c.c. of urine (using phenolphthalein as indicator).

The urine of a patient on hexamethylenamine, if acid, will after standing give a higher test for formaldehyde than when fresh. Feeding acid sodium phosphate, boric acid, benzoic acid, or salicylic acid will

increase urinary acidity where it is low, and in these cases very definitely increase the amount of formaldehyde in the urine. The effect of any of these acid-producing drugs will wear off after a time. When this occurs one can again raise acidity by substituting one of the other drugs in its place, and by thus alternating the drugs acidity may be maintained for some time in some cases, but not satisfactorily in all. It is best not to give these drugs *with* the hexamethylenamine.

In cases of hyperacidity or poor gastric motility there is sufficient conversion of hexamethylenamine to formaldehyde in the stomach to considerably lower the formaldehyde content in the urine. Hexamethylenamine may be given in salol-coated pills in cases of gastric irritability.

Formaldehyde appears in an acid urine after the ingestion of an average dose (15 grains) in from twenty to thirty minutes, and will have disappeared in from eight to sixteen hours. An eight-hour interval of administration will give good results in routine use, although a higher concentration is obtained with more frequent introduction.

The dilution of the drug on excretion largely influences the amount of it that is subsequently converted, as the higher its concentration, the more readily will it be broken down. A polyuria, through the effect of dilution, will largely offset the advantage of large doses.

Disease of the kidney has no influence on the formaldehyde content in the urine. At the level of the kidneys hexamethylenamine in doses of 15 grains three times a day has no antiseptic value.

Formaldehyde is present in the bladder urine in some amount in practically every case receiving 15 grains of hexamethylenamine by mouth three times a day, but this dosage is too small to yield a reasonable antiseptic benefit in every case. F. Hinman (Jour. Amer. Med. Assoc., Nov. 1, 1913).

UNTOWARD EFFECTS.—Bladder irritation, manifested in a sensation of heat or actual burning along the urinary tract, with or without frequent or painful micturition and strangury, is the commonest untoward occurrence following the administration of hexamethylenamine. The irritation is not due to the drug itself, but to the formaldehyde liberated from it, L'Esperance having observed in a large series of cases that patients not excreting formaldehyde were symptomless regardless of the amount of hexamethylenamine taken. Burnam found, moreover, that the tolerance of the bladder mucosa to formaldehyde solution directly introduced varies greatly in different individuals. It need not therefore seem surprising that whereas in occasional cases of already sensitive bladder, $7\frac{1}{2}$ grains (0.5 Gm.) of hexamethylenamine taken two or three times a day is sufficient to produce vesical irritation, daily doses as large as 150 grains (10 Gm.) have been taken without any disturbance resulting. The sensitiveness of the urinary system to the formaldehyde from hexamethylenamine has even been noticed to vary at different times in the same individual.

Other effects occasionally observed after the use of this drug are hematuria or hemoglobinuria, headache, tinnitus, a skin rash resembling that of measles, gastric irritation, diarrhea, and abdominal pain. According to Coleman, blood appearing in the urine after hexamethylenamine is derived from the bladder. Frothingham refers, in addition, to a pain in the back denoting renal congestion, and to the appearance of albumin and casts in the urine. Albuminuria

rarely develops unless some involvement of the kidneys is already present.

Report of experiments showing that even small doses of hexamethylenamine, if long continued, may produce renal irritation. After moderate amounts there is an initial increase in the total quantity of urine passed, due to primary irritation of the kidney structure, but if the drug is continued for any considerable length of time, there is a diminution in the amount excreted. Toxic symptoms are only noted when there is severe renal irritation. Thus one animal showed a marked tendency to lie about and sleep, and looked sluggish and ill, refusing all food, while hematuria was present. Wiggs (*Southern Med. Jour.*, Dec., 1910).

Among 95 cases in which the average dose of hexamethylenamine given was 75 grains (5 Gm.) a day for ten days, painful micturition and hematuria occurred in 7 instances. In each of 3 cases which terminated fatally there was a well-marked hematuria, but at the post-mortem examination it was apparent that it had its origin from the mucous membrane of the bladder and was not due to an acute renal irritation. In the remaining 4 cases the urine rapidly became normal on the withdrawal of the drug. Producing active diuresis by forcing liquids is also useful. S. J. Crowe (*Johns Hopkins Hosp. Bull.*, Sept., 1912).

A case of cystitis due to hexamethylenamine has been reported by Fullerton. The urine was sterile. Some of the symptoms persisted for several weeks.

Report of a case in which large doses of hexamethylenamine caused intense cystitis. The symptoms began after 200 grains (13 Gm.) had been taken over a period of four days. The woman voided urine every ten or fifteen minutes and had pain and burning, especially at the end of urination. The next day another drug was prescribed and the hexamethy-

lenamine ordered stopped. Through a mistake, the patient received 45 grains (3 Gm.) more of the drug during the day, and in the evening, twenty-four hours after the first symptoms, which had increased in severity during the day, she had marked hematuria, passing many small blood-clots as well as pieces of bladder membrane several centimeters square. The urine was acid and contained pus and a considerable amount of albumin. The drug was stopped and appropriate treatment of the cystitis instituted. For three nights and two days after the onset of the hematuria, blood-clots and bladder membrane were passed. Red blood-cells were passed for ten days. The pus and albumin gradually disappeared. Fullerton (*Jour. Amer. Med. Assoc.*, Jan. 13, 1912).

The most common cause of this condition is abnormally high urinary acidity. With low acidity the efficiency of the drug disappears. A middle course is desirable. Wiseman (*Amer. Jour. Med. Sci.*, Aug., 1917).

In nearly all instances discontinuance of the administration of hexamethylenamine after untoward phenomena have appeared is promptly followed by cessation of the latter. Sometimes merely a reduction in dosage will be indicated.

THERAPEUTIC USES.—As a urinary antiseptic hexamethylenamine is generally conceded to be without a peer. In cases of cystitis and pyelitis due to micro-organisms other than the gonococcus and the tubercle bacillus, its use has been widespread. The dose given in these conditions ranges from 4 to 15 grains (0.25 to 1 Gm.), this being administered two or three times daily. Colon-bacillus infections are in a large proportion of cases effectually overcome by hexamethylenamine.

In a case of *tabes dorsalis* in which relaxation of the sphincters was fol-

lowed by the development of a rather severe cystitis, 10 grains (0.6 Gm.) of hexamethylenamine were given hypodermically three times daily for a period of two weeks, without producing local irritation. As a prophylactic measure where catheterization or other genitourinary manipulation is necessary, this drug should be given hypodermically until its administration by mouth can be taken up. F. F. Gundrum (Calif. State Jour. of Med., July, 1911).

In **urethritis**, even of the specific form, the drug has also been employed with asserted advantage by some. In these cases the dose should seldom exceed 5 grains (0.3 Gm.) and usually be even less, though administered four times a day.

In the prophylaxis of urethritis and cystitis, *e.g.*, where instruments are to be introduced in the bladder or ureters, hexamethylenamine is definitely indicated.

Phosphaturia can often be prevented or overcome with hexamethylenamine even where other drugs or dietetic measures have failed.

A patient with locomotor ataxia, under treatment for a year and a half, had suffered from **phosphaturia** for from six to twelve months before he came under observation. Every measure tried to relieve this condition was without success until hexamethylenamine was used, and from that time the phosphaturia gave no more trouble.

Although the patient had been taking the remedy faithfully for a year and a half, no unfavorable effects have been noted. At first 0.5 Gm. (8 grains) four times a day was given, and then the administration gradually reduced to once a day. This did not hold the phosphaturia in check, however, and the remedy had again to be given oftener. Osborne (Monthly Cyclo. of Pract. Med., Sept., 1910).

Buttersack has advocated the persistent administration of hexamethylenamine in **scarlet fever** to prevent the development of nephritis. Of 34 cases in which the drug was given up to the twenty-first or twenty-fifth day, none developed nephritis, though in a few instances a trace of albumin suddenly appeared, with occasional casts, but without altered quantity of the urine or edema. Leech, Morris and others have had similar favorable experiences with the remedies.

In **gall-bladder infections** hexamethylenamine, according to some, proves of value, bacteria in this organ being rapidly destroyed by the formaldehyde set free. In **typhoid fever** especially has the drug been used, in order to prevent relapses arising from storage of bacilli in the gall-bladder with subsequent liberation and reinfection of the bowel; to prevent post-typhoid cholelithiasis, and to sterilize the patient's urine and prevent transmission of the disease. The occasional genitourinary complications of typhoid fever can also probably be prevented with hexamethylenamine. Crowe states that the dose necessary rapidly to free the gall-bladder of typhoid bacilli is 75 grains (5 Gm.) a day, and that usually one or two doses are sufficient. Since the degree of formaldehyde liberation varies in different individuals and at different times, however, it seems evident that no fixed rule as to dosage can be laid down.

Hexamethylenamine recommended in doses of 30 to 45 grains (2 to 3 Gm.) per day in **acute infections of the biliary system**, whether due to pyogenic cocci, to the colon, or to the typhoid bacillus. The author also uses it for the preoperative sterilization of infected gall-bladders. That

the drug is partly excreted in the bile he was able to prove in cholecystostomized patients. The excretion through the bile was as constant, as rapid, and quite as intense as the excretion through the urine. A. Chauffard (*Semaine méd.*, No. 10, 1911).

Hexamethylenamine found useful for **prevention of excessive abdominal tympany after operations**. Ten grains (0.65 Gm.), dissolved in a glassful of water, are given every two hours between meals while the patient is awake, for two days previous to operation. Immediately after operation the nurse dissolves 120 grains (8 Gm.) of the drug in a quart of drinking-water, and as soon as the patient complains of thirst small quantities of this are given at a time, the amount being cautiously increased as the stomach becomes retentive. Thus the patient usually takes and retains the whole of the tasteless drug during the first twelve to twenty-four hours. By this time he can commonly take a glassful of water at a time, and 10 grains (0.65 Gm.) of the drug dissolved in a tumblerful of water are given every two hours, until between 60 and 120 grains (4 to 8 Gm.) are administered each day for seventy-two hours after operation. The drug is then discontinued and the usual postoperative bowel cleansing performed. If excessive vomiting is present or if for any purpose water is given by bowel instead of by mouth, the drug is dissolved in the hot water or saline thus administered. Among over 300 cases in which this measure was employed, but 4 suffered from tympanites, as shown by distention of the epigastrium beyond the level of the ribs. One of these cases was intolerant of hexamethylenamine, while in another only small doses after the operation had been used.

Hexamethylenamine seems to be beneficial in non-operative cases of infection of the bowel and bile-tract. The author has never been forced to operate upon a case of **bile-tract infection** or obstruction from gall-

stones during the acute attack, always carrying them over the stage of pain and fever by rest in bed, restriction of diet, avoidance of purges, administration of drugs quieting peristalsis, and the routine use of hexamethylenamine every two hours for periods of three days at a time. In **acute appendicitis**, where the proper facilities for operation are not at hand, he has seen many cases settle down into a quiet stage by starvation and the measures just mentioned. In **catarrhal jaundice** he reports satisfactory results following a treatment including the administration of 10 grains (0.65 Gm.) of hexamethylenamine every two hours during the waking period. G. P. La Roque (*Therap. Gaz.*, July, 1913).

Forty **typhoid** patients given hexamethylenamine in doses of 0.5 to 0.6 Gm. ($7\frac{1}{2}$ to 10 grains) three or four times daily. Hematuria appeared in 4 instances. Death occurred in 1 case. At autopsy the bladder showed marked desquamation and ecchymoses, and the intestine numerous ulcers, one of which had yielded. In the remaining patients of the series there was neither perforation, intestinal hemorrhage, nor relapse. While hexamethylenamine cannot be considered a specific in typhoid, the generally favorable results obtained invite further trial in this disease. J. Belkowski (*Rev. de méd.*, Aug., 1913).

In various **respiratory disorders** clinical experiences with hexamethylenamine seem to have shown it useful as a destroyer of mucous-membrane infections, although clinical experiments conducted for the purpose of finding out whether or not formaldehyde is excreted in the mucous secretions have not yielded confirmatory results.

In **acute coryza** favorable results from hexamethylenamine have been reported by several observers. According to Austin Miller, it acts promptly and efficiently in most

cases, the irritating, watery secretion of coryza being arrested, and the fever, aching and malaise of **influenza** likewise being overcome. The drug should be taken at the earliest possible moment—when the nose begins to feel “stuffy.” In colds that have already been present several days the results are less gratifying. The greatest value of the drug, according to the experience of one of the writers, is in the prevention of the tracheobronchitis which frequently becomes superadded to acute coryza.

At the onset of a **cold** the author prescribes 3 drams (12 Gm.) of hexamethylenamine divided into 12 powders,—1 powder to be taken in a goblet of cold water four times daily. Copious water-drinking is encouraged, which lessens the possibility of bladder irritation. The latter is the only ill effect of the drug, but it occurs only occasionally and ceases at once when the medicine is discontinued. Austin Miller (*Jour. Amer. Med. Assoc.*, June 10, 1911).

In **acute bronchitis** hexamethylenamine was found by Eisenberg promptly to cause the establishment of free secretion, with great relief to cough, and to make all other symptoms disappear within three to five days. Heitmüller reported in **chronic bronchitis** a change in the character of the sputum from mucopurulent to mucoid, together with diminution in its quantity. **Acute tonsillitis** may be favorably influenced by hexamethylenamine, but in lobar pneumonia and pulmonary tuberculosis it is doubtful if the drug is of any value (Crowe).

Hexamethylenamine administered systematically to **bronchitis** patients and sputum examined. The findings confirmed the assumption that the drug is eliminated in the saliva and bronchial secretions. Zak (*Wiener klin. Woch.*, Jan. 25, 1912).

Hexamethylenamine employed in all cases of common **colds** and in patients suffering from **acute** or **chronic bronchitis**. In colds no other remedies were employed except an initial purgative, with subsequent care that the bowels remained open. Large doses were found best, and as a routine the author gives 10 grains (0.65 Gm.) dissolved in a glass of water four times daily for three to seven days, after which the drug is discontinued. The patient is instructed to drink water copiously. But one patient complained of any irritation of the bladder, which ceased promptly after omission of the drug. Two cases of chronic antrum infection which had resisted operative measures and prolonged local treatment induced the authors to recommend hexamethylenamine as a prophylactic against **sinus infection** from common colds. In both acute and chronic bronchitis hexamethylenamine produces results above comparison with the usually employed remedies. It is decidedly effective in colds, even when the bronchitis stage has been reached, but its chief value is in preventing this. Some cases do not respond to it and in these it is presumed structural changes have occurred. D. Vanderhoof (*Jour. Amer. Med. Assoc.*, Feb. 3, 1912),

Of 43 cases treated with hexamethylenamine, 22 were of **acute bronchitis**, 12 **acute rhinitis**, 8 **influenza** of the respiratory type, and 1 **chronic frontal sinusitis**. In acute rhinitis the dosage was 4 grains (0.26 Gm.) three times daily in half a glass of water for children up to 10 years; twice daily for the following day or so. For children up to 15 years, the dosage was 6 grains (0.4 Gm.) and for adults 10 grains (0.65 Gm.), given in the same manner. In acute bronchitis the patients were kept in bed while the temperature was above normal, and 10 grains (0.65 Gm.) of hexamethylenamine were given three times daily for three days, then twice daily until the subsidence of cough. All were well in four to five days.

Children were given correspondingly smaller doses. In influenza the patients were, of course, placed in bed during elevation of temperature, and 10 grains (0.65 Gm.) were administered three times daily until the temperature was below 100° F. (37.8° C.), then half-doses three times daily until the temperature became normal. In the single case of accessory-sinus disease the drug seemed to exert a favorable action.

Hexamethylenamine must be given in doses large enough to secure its full physiological effect. No untoward symptoms were observed until it was given in fairly large doses (up to 30 grains—2 Gm.—daily). Eisenberg (Jour. Amer. Med. Assoc., June 29, 1912).

In **suppurative otitis media** and in **accessory sinusitis**, acute or chronic, Barton and Brown have become convinced of the value of hexamethylenamine in a number of cases. According to Barton, acute cases are rapidly cured, while chronic cases are ameliorated. Barnes refers to the prompt control of aural discharges by hexamethylenamine. Barton reports having found hexamethylenamine to be eliminated by the mucous membrane of the middle ear and sinuses, as well as that formaldehyde is sometimes present in the discharges. The drug is recommended as a prophylactic of otitis media in infectious diseases commonly complicated by it, and its use has also been advocated prior to surgical operation upon the middle ear or mastoid and the nasal sinuses.

Hexamethylenamine employed in some 15 or 20 cases of **middle-ear trouble** without disappointment in any. In a case of **chronic otitis media** of one year's duration in a child 3½ years old, treated in the usual way without improvement, boric acid irrigations, *t. i. d.*, and hexamethylenamine, 1½ grains (0.1 Gm.),

four times a day, were ordered. In two days the odor of the discharge had disappeared, and in four days the discharge ceased entirely. The author has used hexamethylenamine in **ear-ache**, especially during influenza, with prompt disappearance of the pain. J. A. Gannon (Monthly Cyclo. of Pract. Med., Sept., 1910).

In 2 cases the drug apparently checked the progress of an **acute labyrinthine infection**. S. J. Crowe (Johns Hopkins Hosp. Bull. Sept., 1912).

Upon demonstrating experimentally the appearance of hexamethylenamine in the cerebrospinal fluid, after oral ingestion of therapeutic doses, in sufficient amount to exert a marked inhibiting effect on the growth of organisms (streptococcus) inoculated into this fluid after its removal from the body, Crowe was led to administer it to all cases in which meningeal infection is a possible or threatened complication, including cases of **compound skull fracture**, **tumors of the hypophysis** with neighborhood symptoms necessitating operative procedures through the nose, and **postoperative cerebrospinal fistula**. The statistical results obtained in a large series of cases have appeared to this author clearly indicative of a favorable prophylactic influence. The drug has been used apparently with advantage to prevent complications in **gunshot wounds of the head**, and also as a preliminary to **lumbar or ventricular puncture**. For all these purposes the dose used must be rather large—from 40 to 150 grains (2½ to 10 Gm.) a day, preferably at least 75 grains (5 Gm.). This is best divided into small doses, given freely diluted in water every half-hour; or, the drug may be given with liquid food. In unconscious or nau-

seated patients it can be administered by rectum, from 30 to 60 grains (2 to 4 Gm.) being dissolved in 10 ounces (300 c.c.) of salt solution and allowed slowly to flow into the bowel (Crowe).

Hexamethylenamine given as a routine measure in 35 consecutive cases of undoubted **basal fracture**, with bleeding, or escape of cerebrospinal fluid from the nostrils or ears, without a single instance of secondary meningeal infection. There had been nine deaths ascribed to meningeal infection or brain abscess among 35 earlier cases to which hexamethylenamine had not been given.

Among 20 cases of **compound fracture of the vault**, similar in that there was laceration of the meninges and underlying cortex in each instance, hexamethylenamine was not given and the mortality from infection was 50 per cent. in 8 of the earlier cases. To each of the remaining 12 cases the drug was given immediately after the injury and at frequent intervals thereafter; 10 of the patients recovered.

In cases with constant discharge of cerebrospinal fluid into the nasal cavity or middle ear—not an infrequent complication of a cranial fracture, as well as following certain operative procedures for the relief of increased intracranial pressure—hexamethylenamine proved of great value as a protection against meningeal infection.

In 40 cases of **hypophysis tumor** from 40 to 60 grains (2.6 to 4 Gm.) of hexamethylenamine were given during the twenty-four hours preceding operation, and even larger amounts for several days after operation. In 32 cases there were no post-operative complications whatever; in 9 cases there was an escape of cerebrospinal fluid through the nose for several days following the operation, together with an elevation of temperature, headache, slight stiffness of the neck, etc. Three of these finally succumbed with meningitis; the other

6 cases, however, recovered. S. J. Crowe (Johns Hopkins Hosp. Bull., Sept., 1912).

During epidemics of **cerebrospinal meningitis** and **acute poliomyelitis** the prophylactic administration of hexamethylenamine has been warmly advocated. Experiments of Flexner and Clarke have definitely shown that the drug affords protection against the latter affection. A curative influence also seems to have been established in the sense that in cases of acute poliomyelitis treated with the drug in the prodromal stage, subsequent paralysis may in the majority of cases be prevented. Josefson, of Stockholm, in fact, has reported that of 8 cases in which treatment was begun on the first, second or third day, each recovered without paralysis. The same author, as quoted by Crowe, has also seen many cases at a more advanced stage, with facial or abducens palsy, in which further progress of the disease was apparently checked by large doses of the drug.

The fact that hexamethylenamine has been found to enter synovial fluids suggests its utility in cases of arthritis. The form of this condition in which it has been chiefly tried is **gonorrheal arthritis**. Full doses were found by Crowe in a case of this kind to cause a marked decrease and in ten days complete disappearance of the organisms. The use of the drug is also advised in **pneumococcic arthritis**.

Prouty has reported a case of **orchitis** developing during an attack of tonsillitis, in which hexamethylenamine appeared to yield excellent results.

Case of **orchitis** in a 20-year-old typesetter of good habits, without specific taint, as far as could be discovered, or evidence of blood-poison-

ing. The swelling of the testicle occurred during an attack of tonsillitis, in which treatment by acetylsalicylic acid was ineffective. In view of the bactericidal properties of hexamethylenamine when decomposed within the body, it was administered in 15-grain (1 Gm.) doses every six hours. What appeared at first to be a severe inflammation very rapidly disappeared. I. H. Prouty (Jour. Amer. Med. Assoc., April 20, 1912).

In certain eye affections, including iridocyclitis with hypopyon, and sympathetic ophthalmia, hexamethylenamine has seemed useful to Dinkelspiel and others.

Hexamethylenamine used to arrest fermentation in the stomach content in case of stagnation from stenosis of the pylorus. A patient with a gastric ulcer took 0.5 Gm. (8 grains) of the drug twice a day for four days and the eructations and stomach content became odorless. The patient complained, however, of transient burning in the stomach, due possibly to the drug. Zak (Wiener klin. Woch., Jan. 25, 1912).

Doubts as to the value of hexamethylenamine in conditions other than genitourinary have been expressed by Burnam and others, who consider, on the basis of estimations of the amount of hexamethylenamine or formaldehyde in the bile, sputum, saliva and cerebrospinal fluid after administration of full doses of the former drug, that the resulting solutions of formaldehyde in these fluids are too attenuated to exert any useful antiseptic effect. Hanzlik and Collins deny completely the splitting off of formaldehyde from hexamethylenamine in any of the body fluids except those which are acid, viz., the gastric juice, and, in most instances, the urine.

After administration, hexamethylenamine is present, but does not lib-

erate free formaldehyde in the blood, cerebrospinal, pleural, pericardial, and synovial fluids, the vitreous and aqueous humors, and the urine when truly alkaline. Formaldehyde is liberated in urine which is truly acid, and in the acid gastric contents. The authors do not positively deny the possibility of benefit from the use of hexamethylenamine where there is bile infection. They state that, on account of the rapid absorption of the drug and the usual alkalinity of the bowel contents, no bactericidal action can be expected in the intestinal canal. Many of their experiments revealed, however, formaldehyde in the intestinal contents. P. J. Hanzlik and R. J. Collins (Arch. of Intern. Med., Nov., 1913).

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HICCOUGH (Singultus, Hiccup).—

This symptom, which sometimes becomes extremely distressing, and may even end in death, is due, according to Bertier and other authorities, to a sudden contraction of the diaphragm, causing a sudden motion of the abdominal and thoracic walls, and accompanied by a coarse and inarticulate sound caused by the closing and sonorous vibration of the lips of the glottis. The diaphragmatic spasm is but one of the factors of the syndrome, which comprises other associated phenomena, glottic and gastric. There is a double nervous control of the act of hiccupping: through the phrenic the diaphragm is made to contract; by means of the vagospinal nerves there are brought about the closure of the glottis, the contraction of the stomach, and the relaxation of the pyloric sphincter. A center co-ordinating these movements is supposed to exist in the neighborhood of the vital center and the center of vomiting. Numerous centripetal paths bring the hiccup center into relation with numerous peripheral sources of irritation.

Hiccupping is sometimes preceded by a sort of aura, a sense of epigastric tension. Sometimes diaphragmatic spasm is so violent as to cause a synchronous raising

of the shoulders, limbs, and trunk, rapidly producing fatigue if the attack is prolonged. In other cases the glottic element is the principal one, producing an intense sound like the bark of a dog (a case being reported in which the sound was heard at a distance of three-quarters of a mile). Ordinarily the spasms have a rate of 6 to 15 per minute, but in severe cases there are as many as 60 to 80. They have already been observed in one case synchronous with the cardiac pulsations. Generally hiccup stops during the night; sometimes it persists. In severe cases hiccup causes a considerable amount of functional disturbance: anxious respiration, cyanosis, difficulty of deglutition, and serious impairment of nutrition. In the course of diaphragmatic pleurisy it causes intense pain and insomnia. Speech is sometimes impossible. At times hiccup relieves the distress of dyspeptics by causing eructation of gas. Ordinary attacks of dyspeptic hiccup last a few minutes; those due to inflammation of the pleura or peritoneum may persist for hours or days. Certain hysterical cases have lasted for twenty to thirty years.

ETIOLOGY AND PATHOGENESIS.

—The irritation of the problematic center or centers is traceable clinically to the domain of the vagus (foreign bodies in the lung, pleurisy, affections of the liver, stomach, intestines, peritoneum, esophagus, pharynx), of other visceral nerves (pregnancy, diseases of the prostate, kidneys, bladder, uterus), or the nerves of general sensibility (exposure to cold). Besides these reflex causes of hiccup there are direct central forms of stimulation of the center controlling this act. Thus, it may be due to imagination (hysteria, imitation, epidemicity), to toxic products (uremia, tobacco, alcohol), and to anoxemia (agony, severe hemorrhage). The irritation may affect the centrifugal limb of the reflex arc (luxations of the cervical vertebræ, tumor of the mediastinum, aneurism of the aorta, pericarditis, diaphragmatic pleurisy, wounds of the diaphragm, splenomegaly, and perisplenitis). Hiccup has been observed in the following disturbances: Diseases of the stomach; liquids too hot or too cold, unchewed food, carbonated liquids, in-

digestion; it may be a troublesome accompaniment of cancer, ulcer, and hyperchlorhydria. In nurslings it indicates an overloaded stomach.

In healthy infants which have been fed too much, or irregularly, hiccup indicates at least that a sufficient quantity has been ingested to reach the limit of the digestive capacity of the stomach. Victor Thevennet (*Lyon méd.*, Aug. 27, 1905).

The writer refers to a primipara who in the last 2 months of gestation felt peculiar shocks in the abdomen which succeeded one another more or less rapidly over a period of 5 to 10 minutes. They were quite unlike ordinary fetal movements. The hand of the author was able to feel them. Circulatory troubles of mother and fetus could be excluded as could also uterine contractions. The fetal heart sounds were as if interrupted by the shocks. The child, otherwise normal, had hiccup after delivery. Chapuis (*Revue Méd. de la Suisse Rom.*, Jan.-Feb., 1917).

Affections of the pharynx: aphthæ, abscess, esophageal spasm due to benign or malignant stricture may also act as a cause. This applies also to the following disorders: Diseases of the peritoneum: every time the peritoneum is irritated hiccup is apt to arise; it is less constant in the localized varieties. Intestinal disorders, including dysentery, lumbricoides. Diseases of the liver. Diseases of the spleen, most frequently hypertrophy. Genitourinary disorders, above all; affections of the bladder. Uterine disorders. Pregnancy: in this case hiccup is due to toxemia, like vomiting. Abdominal wounds. Diseases of the respiratory organs, particularly diaphragmatic pleurisy and pneumonia. In the former it is the source of agonizing pain. It is seen in subphrenic abscess. In pneumonia it occurs on the fifth or sixth day and is ordinarily very violent. Mediastinal compression. Pericarditis, in which it is a bad symptom. Exposure to cold. Affections of the peripheral nerves, as in sciatica. Spinal disorders, as displacement of cervical vertebræ.

Hiccup may also be of central origin;

prominent in this connection is hysteria. Boerhaave reported an epidemic in Haarlem. These cases may be easily differentiated from those of symptomatic origin. In the former the glottic phenomenon is the most marked, and the sound produced is intense. The prognosis is good, as regards life, but interference with sleep and nutrition may cause general debility. Emotion occurs as a cause in neuropathic subjects, and sometimes in the course of laughing or crying, when it is really a sobbing. Chorea and epilepsy, intoxications, lead colic, nicotineism, alcoholism, and autointoxications, as uremia, are other causes of hiccough.

Of the hiccough that occurs in the course of infections that of typhoid fever has been most studied. It appears late, most frequently in some epidemics, at first is intermittent and then incessant, sometimes accompanied by biliary vomiting, preventing sleep, interfering with speech and swallowing, and disappearing at the end of a few days. It has been attributed to various causes: abdominal distention, splenic hypertrophy, ulceration of esophagus, and most recently to the action of the typhoid toxins upon the bulbar center. Hiccough is also seen in scarlatina, scurvy, yellow fever, cholera, and hydrophobia, and also in cachexia, hemorrhages, death agony, bulbar diseases, and cerebral affections. In diagnosis hiccough may be easily distinguished from pharyngeal and laryngeal spasms, yawning, and aerophagia (Bertier).

In a case seen by the writer, hiccough persisted unmodified by all measures until the death of the patient, six months after the hiccough had first commenced to torment him. Autopsy showed the presence of a small tumor in the hilus of one lung, evidently a primary malignant growth, and probably responsible for the singultus by pressing upon the phrenic nerve. Green (Med. Klinik, July 16, 1911).

Case of hiccough in a female being treated for hepatic cirrhosis. The usual routine treatment proving of no value and the patient being in a dying condition, the ears were examined and impacted wax was found

and removed. The hiccough ceased permanently. B. O'Reilly (Can. Lancet, Feb., 1914).

TREATMENT.—The physician is not called in, as a rule, until all the usual family resources—**tickling of the pharynx, the swallowing of ice, salt, lemon-juice, vinegar, strong spirituous liquors; holding the breath a minute or two; traction on the tongue for several minutes**—have been tried and proved useless. To these procedures which sometimes prove effectual by causing inhibition of the motor phenomena might be added: **Compression of the auditory meati with extension of the head, chloroform compresses on the epigastrium, epigastric ether pulverizations, raising of the hyoid bone, drinking slowly while pinching the nose, sinapisms, pharyngeal irrigations with cold water, compression of the fists, compression of the cubital region, compression of the ball of the thumb with the little finger, a little salt or sugar placed on the tongue, and thrusting the tongue systematically out of the mouth; increasing the oxidation of the blood by means of 40 to 50 rapid and deep respirations.** Among the more difficult practices may be mentioned: **Catheterization of the esophagus, tetanizing galvanization of the esophagus.**

Obstinate hiccough is sometimes relieved by having the patient **hang, with the arms extended**, from a beam or pole, and with all the abdominal muscles tense hold his breath as long as possible. Where hiccough is associated with flatus, **intestinal irrigation with soapsuds and turpentine** is often efficacious. Donnelly (N. Y. Med. Jour., April 29, 1911).

Mechanical interference with movements of diaphragm; forcible manual compression of the diaphragm, forced expiration or inspiration, abdominal bandage, and suspension of respiration. A suggestive method is that of Kannegiesser, which consists in administering **effervescing fluids** to dilate the stomach. Arrest of the diaphragm may also be carried out by **compressing the abdomen with the patient's thighs.**

Case of distressing hiccough in the course of an attack of influenza. No

benefit having been derived from atropine sulphate, although the patient's mouth became parched, he was given in separate glasses a solution of 5 Gm. ($1\frac{1}{4}$ drams) **citric acid** and of 5 Gm. ($1\frac{1}{4}$ drams) **sodium bicarbonate**, hoping by the distention of the stomach from the effervescing fluids to act on the diaphragm from below. The procedure was a complete success, the hiccough ceasing at once. Recurrence of the hiccough having occurred at night, repetition of this measure then failed to relieve, as did also the next day rhythmic traction of the tongue and holding the breath. He was then given a little **sodium bicarbonate** in water, and the hiccough ceased at once for a few hours, but returned then and persisted until the patient took some **warm oatmeal gruel**. This arrested the hiccough and had the same effect the next day, after which there was no further trouble. Kannegiesser (Med. Klink, March 26, 1911).

As a last resort in a very serious case, the patient so exhausted that he had been brought to the hospital, the writer had the patient's **legs flexed** on the abdomen and **pressed against the abdomen** so that the intestines were forced up against the diaphragm as much as possible. The hiccough became at once weaker and the intervals longer and in ten minutes the hiccough had ceased entirely. They began again after two hours, but were arrested anew by the same measure. Jödicke (Med. Klinik, May 28, 1911).

In hysterical cases **valerian** and any of the above methods, to influence autosuggestion in addition to their reflex effects, often do good. If not, **hypnotism** may prove effectual. **Lavage of the stomach** is sometimes effective in these cases, especially if it has never been used before on them. **Musk** is sometimes helpful in these cases.

Postprandial hiccough is often chronic and requires **regulation of the diet**, but a stubborn gastric case is best relieved by means of an **emetic**. Such cases are often reflex, though occasionally due to autoin-

toxication. The various disorders of digestive tract enumerated under ETIOLOGY should be sought in persistent cases. This applies to all other disorders enumerated.

When a baby begins to hiccough, it is often given **granulated sugar**, and many times with good result. Or a teaspoonful of plain **water**, or of **water with anise or peppermint**, any of which may be successful. An older child may be made to **hold his breath** for a portion of a minute, or to **drink rapidly** a glass of **water**, either of which methods may hold the diaphragm quiet long enough to overcome the tendency to spasm. Adults can hold the breath longer, and frequently this will bring about a cessation of the hiccough.

Sometimes provoking **sneezing** will stop hiccough. Also, if a patient is well and strong, any slow muscular effort, as **lifting a weight**, or especially **pulling the body** several times up by the **hands holding onto** any trapeze arrangement, is often successful. If these simple measures do not afford relief, and the stomach is overloaded, an emetic, as **ipccac**, may be administered. Editorial (Jour. Amer. Med. Assoc., July 29, 1911).

Inveterate case stopped when the **eyeballs were compressed**. Aquino (Semana Med., Apr. 19, 1917).

Obstinate hiccough cured by 1 dose of **quinine**, 10 grains (0.6 Gm.). A morsel of **sugar dipped in vinegar** stops it. (Amer. Med., Oct., 1917).

Case of 13 months' duration, associated with hysterical monoplegia, cured by **suggestion** during intoxication with **bromides**. Hurst (Seale Hayne Neurol. Studies, Sept., 1918).

The toxemia to which uremia, a frequent cause of distressing hiccough, is due is best relieved by **hot-air baths**. In some cases this may be assisted by means of **pilocarpine hydrochloride**, $\frac{1}{4}$ grain (0.016 Gm.) being administered hypodermically.

As emergency remedies a large number have been tried unsuccessfully in most instances. The action of **morphine** is, as a rule, only temporary; this applies also to **atropine**, which often proves ineffectual. **Gelsemium** has been praised, but the

preparations available in the shops are often defective in strength and quality.

Hiccough is a not uncommon complication of convalescence in severe sunstroke cases. In 3 such cases **gelsemium** gave immediate and striking benefit. A thoroughly trustworthy fluidextract must be used. The initial dose given by the writer is generally 2 minims (0.12 c.c.). In some cases this is sufficient to relieve, but, as a rule, it has to be increased. W. L. Bauer (N. Y. Med. Jour., May 6, 1911).

Chloral hydrate and the **bromides** have been highly praised by some and found ineffectual by others. But inasmuch as the numerous possible causes of the symptom are often obscure, a remedy capable of good in one case might prove ineffectual in another. **Scopolamine hydrobromide**, $\frac{1}{200}$ grain (0.0003 Gm.) orally or hypodermically, repeated if necessary, has been lauded. This applies also to **nitroglycerine** in doses of $\frac{1}{400}$ grain (0.0006 Gm.) repeated in one or two hours as needed. **Adrenalin** has been recommended. **Drainage of the gall-bladder** is sometimes necessary.

Case of obstinate hiccough in a patient suffering from renal colic in which large doses of the usual drugs and gastric lavage failed. On the eleventh day **adrenalin** proved promptly effective. The patient took 10 drops of the 1:1000 solution; at once the hiccough became milder and less frequent, and, upon repeating the dose half an hour later, the symptom completely and permanently disappeared. J. Ségal (N. Y. Med. Jour., from Jour. des praticiens, Aug. 23, 1913).

A prompt remedy in some instances, is **amyl nitrite**, a few drops being inhaled at intervals, increasing in length as the hiccoughs become fewer. **Chloroform** inhalations, sometimes to the stage of general anesthesia, may become necessary. Post-operative hiccough is best prevented by giving only a nitrogen-free diet or water.

Case in which all the usual methods brought no result. The writer then gave 10 drops of a saturated solution of **menthol in spiritus vini rect.**, in a little hot water. This was to be

repeated every hour if necessary. With the first dose relief was experienced, and after 4 doses in the first 24 hours there was no recurrence. Mead (Med. Record, Jan. 10, 1914).

EPIDEMIC HICCOUGH.

This has been attributed to some specific infection. Lhermitte (Presse méd., Dec. 18, 1920) considers this disease one of the numerous manifestations of epidemic encephalitis. The first observation of febrile epidemic hiccough was made by Economo as part of an epidemic of encephalitis—not the original outbreak, but the myoclonic epidemic of the winter of 1919-1920. So far as Austria was concerned the hiccough antedated the encephalitis. The latter exhibited extensive polyclonic manifestations, including spasms of the diaphragm, which recalled the original outbreak of isolated hiccough. Economo was nevertheless very conservative in connecting the 2 manifestations—the idiopathic and symptomatic hiccough. The same association of the 2 has been seen in Paris and Switzerland and the conclusion is hardly escapable that idiopathic hiccough may be a monosymptomatic encephalitis.

P. Gautier (Revue Méd. de la Suisse Rom., May, 1920) observed 5 cases of intense spasmodic hiccough in Geneva, coming on suddenly, persisting for from 2 to 4 days, and then disappearing with equal suddenness, without the treatment having much effect. The patients were 4 men of 30 to 45, and 1 woman of 46. The lumbar puncture fluid was found practically normal in the 1 case examined.

In some cases the hiccough appears to be accompanied by mild catarrhal symptoms of influenzal origin. A patient examined by Jenkins (Lancet, Jan. 22, 1921) had a profuse yellow nasal secretion of thin consistency. Besides staphylococcus, a very minute bacillus, indistinguishable from *B. influenzae*, was found in culture plates. The organism was Gram-negative but did not take any of the ordinary stains well. A fairly strong solution of carbol-fuchsin was necessary in order to obtain a well stained film. The colonies and films from subcultures did not differ from those of the original culture. No growth occurred on plain nutrient agar.

TREATMENT.—Any of the measures described above may be employed besides treatment of the causative disorder. Macht (Med. Rec., July 24, 1920) found **benzyl benzoate** invaluable in persistent hiccough of both adults and children. This is best given in a 20 per cent. solution in alcohol, the dose being from 20 to 40 drops in water or milk. To children the solution can be given in sugar, water or milk.

HOLOCAINE (amidine) is a condensation product of parphenetidin and acetphenetidin. It is always employed in the form of the hydrochloride, which occurs in small, colorless crystals, neutral or feebly alkaline. It dissolves in 50 parts of water (more easily in boiling than in cold water) and is freely soluble in alcohol. Its solution in water is clear and colorless, except if boiled in a glass vessel, when turbidity develops, owing to liberation of a small amount of alkali from the glass, which unites with the HCl, thereby causing precipitation of the insoluble uncombined holocaine. To avoid turbidity in the preparation of the solution, a porcelain vessel may be used. Bottles in which holocaine solution is to be kept should previously have been boiled in dilute hydrochloric acid and rinsed in distilled water. Holocaine solutions keep well. The drug is not official.

PHYSIOLOGICAL ACTION.—Holocaine is a local anesthetic agent, like cocaine, and in addition possesses some antiseptic power. Its anesthetic action, which is exerted more rapidly than that of cocaine, is preceded by a distinct burning sensation, manifest whether the drug be used in the eye or injected into the skin. The drug also tends to produce redness of the tissues with which it is brought into contact. Unlike cocaine, it does not dilate the pupil or diminish intraocular tension, and it exerts less, if any, drying effect on the cornea.

As for its systemic action, holocaine presents no advantage over cocaine. According to Zunz, it is, in fact, more toxic than cocaine, and resembles strychnine in its action, death in experimental poisoning being due to "cramp asphyxia." Braun points out that only 0.01 Gm. ($\frac{1}{16}$ grain) of holocaine is required to bring on convul-

sions in a rabbit, and advises caution in the use of the drug as a local anesthetic.

THERAPEUTICS.—Holocaine is used as a local anesthetic chiefly in ophthalmic surgery. The solution of the hydrochloride generally employed is of 1 or 2 per cent. strength. Instillation of 1 or 2 drops of this solution brings on analgesia in less than one minute; and if the instillation is repeated after an interval of forty seconds, absolute corneal anesthesia will supervene half a minute later. This condition will persist for ten minutes, and the analgesia will continue for five minutes after the return of tactile sensibility (Zunz). By repeated instillations, the anesthetic effect can be kept up as long as desired. Where the anterior chamber of the eye is opened, the drug will act as quickly on the iris and ciliary body as it does on the cornea. The anesthesia produced by holocaine equals in intensity that of cocaine, while not lasting quite as long. Some surgeons prefer it to cocaine in operative work on the eye. According to Derby, it causes a greater degree of insensibility of the iris than cocaine. De Schweinitz, in making observations of the intraocular tension with Schiötz's tonometer, instills a 2 per cent. solution of holocaine three times at three-minute intervals. The drug is also useful for purely analgesic purposes in a variety of ocular affections, such as **vernal conjunctivitis**, **phlyctenular** or **relapsing traumatic keratitis**, **glaucoma**, and especially in **corneal ulcer**, where holocaine, applied directly to the ulcerated surface, exerts a favorable germicidal effect, in addition to relieving photophobia (Derby). Jackson has advised the use of holocaine as local anesthetic in the removal of **foreign bodies** from the eye, on the ground that it will protect the cornea from infection through its antiseptic action.

The vasodilating tendency of holocaine can be overcome, and its anesthetic power slightly increased, by adding to the solution a minute amount of epinephrin.

Holocaine should not be used for anesthesia by intra- or sub-cutaneous injection, its toxicity being far in excess of that of agents such as novocaine, stovaine, beta-eucaine, etc. Nor should it be used internally. From instillation into the eye in

customary amounts, however, little or no danger of a toxic action seems to exist.

S.

HOMATROPINE.—When atropine or hyoscyamine is heated with baryta water, the alkaloid is decomposed into tropine (another alkaloid) and tropic acid. Tropine, mandelic (oxytoluic) acid, and dilute hydrochloric acid are then mixed, and gentle heat is applied for a prolonged period; when the mixture has evaporated down, the alkaloid homatropine crystallizes out in deliquescent, colorless, prismatic crystals. Homatropine [$C_{16}H_{21}NO_3$] is freely soluble in alcohol, ether, chloroform, and oil, but only slightly in water. Its salts with hydrochloric, hydrobromic, and sulphuric acids are white and crystallize well.

PREPARATIONS AND DOSE.—Homatropine is official only in the form of the hydrobromide (*homatropinæ hydrobromidum*), which occurs in small, white, lustrous crystals, soluble in 6 parts of water and in 33 parts of alcohol. A solution of homatropine hydrobromide in water is quite permanent. Though this alkaloid is generally used locally, it may also be given internally, in doses of $\frac{1}{120}$ to $\frac{1}{60}$ grain (0.0005 to 0.001 Gm.).

In addition to aqueous solutions of the hydrobromide, a 2 per cent. solution of the uncombined alkaloid in castor oil has been used for ocular instillation. Disks of glycerogelatin, each weighing about $\frac{1}{60}$ grain and containing $\frac{1}{100}$ grain of homatropine hydrobromide, are recognized in the British Pharmacopœia (*lamellæ homatropinæ*); they are likewise intended for use in the eye.

PHYSIOLOGICAL ACTION.—The physiological action of homatropine resembles that of atropine. It dilates the pupil very rapidly and energetically, but the effect passes off in twenty-four to forty-eight hours, whereas the mydriasis of atropine lasts for ten to fourteen days, and that of hyoscyamine for eight or nine days. Repeated instillations of homatropine solution (1 or 2 per cent.) may cause a lowering of the pulse rate, which is, however, only temporary. Slight hyperemia of the conjunctiva often attends its use, but this generally disappears by the

time the full effect of the drug has been developed (Jackson). Instillations of strong solutions (4 to 5 per cent.) induce a burning sensation on the conjunctiva, and if a large amount has been used, the bitter taste of the alkaloid becomes perceptible, but without the dryness of the pharynx which follows the use of atropine. The action of homatropine on the circulation differs from that of atropine in that the former lessens the pulse rate—probably through vagus stimulation—and lowers the arterial pressure. Unlike atropine, again, it does not induce a skin eruption.

POISONING BY HOMATROPINE.—

No fatal cases of poisoning have been reported from the medicinal use of the remedy in question. This, no doubt, results from the almost exclusive use of homatropine by instillation in ophthalmology. According to Jackson, complaint of a bitter taste is the only common extraocular symptom noted after homatropine instillation. De Schweinitz and Hare, in experiments on frogs, found that this drug in large doses first alters the respiration to the Cheyne-Stokes rhythm, then arrests it completely; this is succeeded by a tetanic condition and later by general paralysis, the peripheral nerves and muscles remaining, however, untouched. The cardiac function is retarded and pulse rate diminished, but the respiratory paralysis is the cause of ultimate death.

Case of homatropine idiosyncrasy in a neurotic patient suffering from eye-strain. Homatropine hydrobromide was used, 2 drops of a 10 grain (0.65 Gm.) to the ounce (30 c.c.) solution being instilled into each eye at intervals of fifteen minutes. The solution had been freshly prepared and was used upon other patients without bad effect. Cycloplegia was produced within forty-five minutes, the patient becoming quiet and subdued. During the shadow test she became pale, dizzy, and fainted. This soon passed off and was succeeded by mild delirium and incoherent speech, which persisted for about twenty-four hours. At the end of five days the mydriasis disappeared. S. H. Brown (Annals of Ophthal., April, 1906).

Case of a man 30 years of age who was refracted without exhibiting any symptoms other than a flushing of the face. The solution used had been freshly prepared in the ordinary strength of $\frac{1}{2}$ grain (0.032 Gm.) to $\frac{1}{2}$ dram (2 c.c.), and 1 drop instilled every ten minutes for one hour. After leaving the office he started for home, but had not reached there some time after. After a careful search he was found sitting on a curbstone several squares away from the office and in an opposite direction to his home. Upon being taken home he said that he had had no idea as to the proper direction to take and had wandered aimlessly about the street as long as his weakened legs would carry him, and then sat down and gone to sleep. After rest in bed in a darkened, quiet room he soon recovered his natural poise. A second case was that of a girl 12 years old who while the drops were being put in her eyes, complained of being tired and wanted to go to sleep. When she walked into the office her mother had to hold her up. She became quite violent, striking at anyone who came near. Her speech was confused and incoherent, with silly laughter, picking at imaginary objects, great restlessness, etc. After waiting two hours she was taken home and put to bed for some hours. E. G. Whinna (Homeo. Eye, Ear, and Throat Jour., Aug., 1909).

A physician, aged 50 and in excellent health, had a drop of a weak solution of cocaine, followed by a wafer containing cocaine and homatropine, of each, $\frac{1}{50}$ grain (0.0013 Gm.), put into his eyes by an oculist one morning. On the afternoon of the next day a well-circumscribed, bright-red, raised, edematous patch appeared on the penis and scrotum. It was very itchy and tinglingly hot. Next day a red patch appeared on the dorsum of the right foot. Two days later there appeared two red papular patches over the front of each thigh. The feces were now dry. The small toes of the right

foot became red, swollen, hot, and itchy, and the sputum was noticed to be a little more viscid than normal. The dilatation of the pupils had by this time almost disappeared. Six days after the medication, the eruption was rapidly decreasing, but the skin was still dry and hot, and for two days the tongue had been rough as felt against the palate; it tingled slightly, and there was a sweetish taste in the mouth.

The disturbances were evidently due to the homatropine, as they occurred coincidentally with the dilatation of the pupils and subsided with their contraction; they were vasodilatory, and therefore in accordance with the eruptions of belladonna and atropine. D. W. Montgomery (Calif. State Jour. of Med., June, 1913).

Treatment of Poisoning by Homatropine.—The treatment of poisoning by this remedy is similar to that of atropine poisoning. If the drug has been taken internally, the stomach is to be evacuated by **emetics** and the **stomach-tube**. **Tannic acid** and **animal charcoal** should then be administered, and **emetics** again given, followed by **castor oil**. **Artificial respiration**, **heat**, **stimulants**, and **hypodermics** of **strychnine** are useful to support the respiration. **Morphine** may be given carefully as a physiological antidote.

Case of a young lady of 26 who had had homatropine drops instilled previously without ill effect. A 2 per cent. solution of the hydrobromide was ordered, 2 drops to be put in each eye every five minutes for half an hour, beginning one hour before the time of the appointment. After 2 instillations the patient felt dizzy and faint and twenty minutes later "collapsed." She was found highly nervous, complaining of dizziness and fullness of the head, with face congested, skin hot and dry, pupils dilated, and mucous membrane of mouth and throat so parched that swallowing was almost impossible; pulse 130 and weak; respirations rapid. The patient soon lapsed into unconsciousness. **Strychnine**, gr. $\frac{1}{50}$

(0.002 Gm.), was given, followed half an hour later by gr. $\frac{1}{60}$ (0.001 Gm.). Tincture of opium, $\text{m} \times$ (0.6 c.c.), was administered as an antidote, and repeated later; also **strong black coffee**; **cold compresses to the head**, and **hot-water bags to the feet**. These measures were followed by an **enema**, and the patient's condition improved considerably. Later the pulse became weak and the finger-tips cyanotic. Gradually the symptoms moderated and a busy, talkative delirium supervened. Next morning the patient was quite rational, but depressed and nauseated; the urine was less in quantity and dark (the patient was menstruating). The patient complained of extreme weakness and a faint feeling about the heart for several days. The pupils remained dilated one week after the instillation of $\frac{1}{2}$ grain (0.013 Gm.) of homatropine. J. R. S. Shannon (N. Y. State Jour. of Med., June, 1909).

The local effects of homatropine in the eye can be readily overcome when this is desired—*e.g.*, in a case of glaucoma where the drug has been used by mistake—by instillation of a solution of eserine.

THERAPEUTICS.—Homatropine is almost exclusively used by ophthalmologists to dilate the pupils, as well as, sometimes, to paralyze the muscle of accommodation for the purpose of correcting anomalies of refraction. Mere pupillary dilatation, such as is required in the examination of the crystalline lens for **cataract**, is more easily secured with homatropine than paralysis of the ciliary muscle. For the latter purpose, good results are obtained only by repeated instillation (at the upper border of the cornea—Jackson) of 1 drop of a 4 grain (0.26 Gm.) to the ounce (30 c.c.) solution every five or ten minutes or the same amount of an 8 or 16 grain (0.5 or 1.04 Gm.) to the ounce (30 c.c.) solution every fifteen minutes for an hour and a half. After this period, forty minutes more should be allowed to elapse before the examination for refraction is made (De Schweinitz). The paralysis of accommodation resulting from such use of homatropine disappears

in about forty-eight hours. For therapeutic uses in ophthalmology, atropine is generally used, although for incipient cataract Risley prefers homatropine, especially where there is discomfort without increased ocular tension.

Among 1000 patients in whom homatropine was used there were 22 where incomplete paralysis of accommodation was suspected. These were examined under a stronger mydriatic, and of the 44 eyes only 6 showed a higher refractive error than had been noted under homatropine. Some samples of homatropine are irritating. The amount of the drug commonly employed—from $\frac{1}{6}$ to $\frac{1}{4}$ grain (0.01 to 0.016 Gm.)—rarely produces constitutional symptoms. Edward Jackson (Annals of Ophthal., Jan., 1901).

After completing an examination under homatropine, the author puts in the eyes a 1 per cent. solution of eserine sulphate, combined with 2 per cent. pilocarpine hydrochloride. The pupil usually returns to its normal size in about one hour if this solution is used three times at twenty-minute intervals, and the accommodation is restored within twelve hours. P. A. Callan (Merck's Archives, Nov., 1906).

Where **foreign bodies** have been impacted in the **cornea** for several days, with ulceration and some injection of the ocular conjunctiva and possible scleral inflammation, a few drops of homatropine solution remove the symptoms in twenty-four to forty-eight hours, and the rapid restoration of accommodation is most gratifying to the patient. In **episcleritis**, **scleritis**, and mild **iritis**, paralysis of the accommodation is of great inconvenience to the patient, yet the pupil must be dilated. A few drops of homatropine will yield a cure in two or three days and accommodation will return in four or five days. In **iritis** and **iridocyclitis** in the elderly, with increased tension, where a mydriatic is often poorly borne, homatropine is indicated. A change

to a miotic then brings its good results much more quickly than if another drug has been used. In cases of severe inflammation of several weeks' duration, employing homatropine will enable the patient to use his eyes for near work two days after the surgeon decides it is safe to discontinue the drops, thus permitting a return to business at least a week earlier than when atropine has been used throughout the case. Emerson (Ophthalmic Record, Sept., 1910).

The writer observed 5 cases in which the use of small amounts of homatropine into the eyes for purposes of **refraction** was followed by glaucoma. A review of the literature shows this occurrence to be rare—not over once in 10,000 cases—but steps should always be taken to prevent it. Three of the 5 cases suffered permanent damage to vision, while the other 2 were cured by the immediate use of physostigmine. The latter agent should be used as a routine following the employment of such mydriatics as homatropine, excepting in the case of young children. For every patient who has had homatropine, there should be prescribed from 10 to 15 drops of a solution containing 1 grain of physostigmine to the ounce. The patient should use 1 drop, 3 times daily, until the pupil has returned to normal and sight for near objects is restored. H. Gifford (Jour. Amer. Med. Assoc., July 8, 1916).

W. and S.

HYDRASTIS.—*Hydrastis Canadensis*, the dried rhizome and roots of which constitute the official *Hydrastis*, U. S. P., is a small, perennial herb, termed in the vernacular golden seal, yellow puccoon, yellow root, etc. In recent years its growing scarcity has resulted in both a marked increase in price and frequent sophistication of the crude drug. The dried herb has a distinct odor and a peculiar, bitter taste.

Hydrastis contains two principal alkaloids, *hydrastine* and *berberine*; a third alkaloid, *canadine*, is found only in very small amount. Although berberine is found in greater quantity than hydrastine, the latter is the characteristic alkaloid. The percentage of it present in the crude drug varies from about 2 to 4.5. Berberine is peculiar among alkaloids as a class in having a yellow color, and occurs in many other plants besides hydrastis, including *Berberis aquifolium* (Oregon grape), *B. vulgaris* (barberry), *Coptis trifolia* (goldthread), *Jateorrhiza palmata* (calumba), *Xanthoxylum Americanum* (prickly ash), etc.

Hydrastinine is an artificial alkaloid produced from hydrastine by oxidation with potassium permanganate or nitric acid. Hydrastine and hydrastinine are closely allied chemically to narcotine and cotarnine, the former an opium alkaloid.

PREPARATIONS AND DOSE.—

Hydrastis, U. S. P., the crude drug, of yellowish to grayish-brown color, is officially required to contain 2.5 per cent. of hydrastine. Dose, 30 grains (2 Gm.).

Fluidextractum hydrastis, U. S. P. (fluidextract of hydrastis), prepared by maceration and percolation of the powdered drug with a 10 per cent. mixture of glycerin with equal parts of alcohol and water. It is required to contain 2 Gm. of hydrastine in every 100 c.c. Dose, 30 minims (2 c.c.).

Glyceritum hydrastis, U. S. P. (glycerite of hydrastis; aqueous fluidextract of hydrastis), made by maceration and percolation in a mixture of glycerin, alcohol, and water containing over 50 per cent. of the first-

named fluid. The preparation forms a clear mixture with water, and each c.c. of it contains the water-soluble constituents of 1 Gm. of the crude drug. Dose, 30 minims (2 c.c.).

Tinctura hydrastis, U. S. P. (tincture of hydrastis), a 20 per cent. preparation, required to contain 0.4 Gm. of hydrastine in every 100 c.c. Dose, 1 to 2 fluidrams (4 to 8 c.c.).

Hydrastina, U. S. P. (hydrastine) [$C_{21}H_{21}NO_6$], occurring in white prismatic crystals, bitter to the taste and permanent in the air. It is practically insoluble in water, moderately soluble in ether and cold alcohol, and easily soluble in chloroform, benzine, and warm alcohol. Dose, $\frac{1}{8}$ grain (0.012 Gm.).

Hydrastininae hydrochloridum, U. S. P. (hydrastinine hydrochloride) [$C_{11}H_{11}NO_2.HCl + H_2O$], occurring in light-yellowish needles or a crystalline powder, with a bitter taste. It is freely soluble in water and alcohol, but dissolves only sparingly in chloroform and ether. Watery solutions of it, especially when very dilute, exhibit a blue fluorescence. Dose, $\frac{1}{2}$ to 1 grain (0.03 to 0.06 Gm.).

Hydrastinae hydrochloridum, U. S. P. (hydrastine hydrochloride) [$C_{21}H_{21}NO_6.HCl + ag.$], occurring as a white, amorphous powder, soluble in water. Dose, $\frac{1}{6}$ to $\frac{1}{2}$ grain (0.01 to 0.03 Gm.).

Liquor hydrastinae compositus, N. F. (colorless hydrastine solution), with alkaline chlorides. Dose, 1 fluidram (4 c.c.).

The following unofficial preparations of hydrastis are sometimes used:—

Berberine ("hydrastia") hydrochloride [$C_{20}H_{17}NO_4.HCl + 2H_2O$], occurring in bright-yellow crystals or as an amorphous powder, with a

strongly bitter taste. It is soluble in 300 parts of cold water, more soluble in hot water, and slightly soluble in alcohol. Dose $\frac{1}{2}$ to 5 grains (0.03 to 0.3 Gm.).

Hydrastin, a dark-brown resinous extract from the crude drug, containing a mixture of the alkaloids. Dose, 3 to 10 grains (0.2 to 0.6 Gm.).

Mistura rhei alkalina, N. F. (alkaline mixture of rhubarb), containing rhubarb and hydrastis in small amounts in a flavored, alkaline menstruum. Dose, 1 fluidram (4 c.c.).

MODES OF ADMINISTRATION.—The fluidextract is the preparation generally employed for internal administration. Its taste may be disguised in some such mixture as the following:—

R Fluidextracti hydrastis,
Aqua aurantii florum,
Syrupi cinnamomi
(N. F.)āā ʒiiss (10 c.c.).
M. Sig.: Teaspoonful every two hours.

When given as a bitter tonic hydrastis should be ordered taken before meals. Adolphus recommends a combination of hydrastis with nuxvomica, taraxacum, and podophyllum. Debove, Pouchet, and Sallard use the following mixture in metrorrhagia:—

R Tincturae hydrastis ʒiiss (10 c.c.).
Tinctura hamamelidis . ʒv (20 c.c.).
Tinctura viburni pruni-
folii m℥ (3 c.c.).

M. Sig.: Teaspoonful every two hours in a half-glassful of mint infusion.

Hydrastine may be given in pills or cachets, or, in the form of the hydrochloride, in solution. Hydrastinine hydrochloride is often administered hypodermically, to secure prompt hemostatic effects. The following combination has been prescribed in a pill (Debove):—

- R *Hydrastininæ hydro-*
chloridi gr. xv (1 Gm.).
Acidi gallici gr. lxxv (5 Gm.).
Extracti ergotæ
aquosi ʒj (4 Gm.).

M. Ft. in pil. no. L.

Sig.: One pill every fifteen minutes up to 4 as a minimum and 12 as maximum.

PHYSIOLOGICAL ACTION.—

Taken internally, hydrastis acts as a bitter, increasing the appetite and promoting the secretion of saliva and gastric juice. It has been credited with cholagogue properties, and is believed also to increase the secretions of the intestinal glands. These effects are due to the berberine it contains.

There is little, if any, evidence of a general action on the nervous and circulatory systems after ingestion of ordinary doses of hydrastis. The effects succeeding absorption of toxic doses are essentially those of hydrastine, berberine being relatively inert. The primary effect of *hydrastine* is exaggerated reflex irritability, due to excitation of the spinal cord, followed, if the amount given be large enough, by convulsions of the strychnine type. These are followed by general motor paralysis, ascribed by Cerna to an action not only on the spinal cord, but on the peripheral motor nerve-structures and the muscles themselves. As regards the effects of hydrastine on the circulation, some degree of uncertainty still prevails. The majority of observers aver that small doses, *i.e.*, therapeutic doses, cause a rise in blood-pressure, due to contraction of the vessels (central, according to Cushny) and perhaps in part to acceleration of the heart beat. Large, *i.e.*, toxic, doses are well known, on the other hand, to produce a fall of blood-pressure by depressing the heart and either directly or indirectly

(through the vasomotor center) removing vascular tone. According to Cerna, hydrastine tends to abolish the irritability of muscular tissue in general. The respiratory rate is at first increased, then diminished, by it; in fatal poisoning, death takes place from respiratory failure. Locally applied, hydrastine exerts a slight anesthetic action. According to Kehrer, it augments the tonicity of the uterus and the power of its contractions, whether administered systemically or applied directly to the excised organ. Cerna found that in hydrastine poisoning the salivary and biliary secretions are largely increased, especially the latter. Marfori ascribes a certain cumulative action to hydrastine. The drug is excreted largely or exclusively in the urine, in unchanged form.

Report of experiments on dogs showing that intravenous injection of fluidextract of hydrastis causes a prompt fall of blood-pressure. With small doses the pressure promptly returns to normal and there may be a slight rise above normal. With larger doses (from 0.07 c.c. to 1 c.c. per kilogram—1.2 to 16 minims per 2½ pounds—of body weight) there is only partial recovery, or the pressure may remain low. The pressure changes are attributable to depression, followed by stimulation, of the heart muscle. Very large doses depress and paralyze the vagus and vasomotor system; otherwise there is no evidence deduced from the myocardiograms and oncometer that the vasomotor system plays any important rôle in the blood-pressure changes.

Hydrastine and berberine cause qualitatively the same blood-pressure changes, although berberine is the most active and is responsible for about 85 per cent. of the effect of hydrastis. Hydrastis given by the

mouth or hypodermically causes no change in the blood-pressure, heart rate, or respiration. Hydrastinine causes a rise of blood-pressure above normal, usually preceded by a slight fall when injected intravenously. The rise is well sustained, and is principally caused by stimulation of the cardiac muscle. W. Whitridge Williams (Jour. Amer. Med. Assoc., Jan. 4, 1908).

Berberine in large doses causes merely a loosening of the bowels, without general symptoms. Poisonous amounts cause, in addition, tremor, a fall in blood-pressure, general weakness, and albuminous or bloody urine, followed either by slow recovery or, after hypodermic administration of the drug, possibly by death from respiratory failure.

Hydrastinine differs from *hydrastine* in causing a more marked and more prolonged rise in blood-pressure. This is owing to the fact that it does not depress the heart like *hydrastine*, though constricting the vessels by stimulation of the vasomotor center and possibly also of the vessel walls themselves. (Bunge, in his experiments, observed contraction of the spleen due to the action of the drug on the vessels.) Another difference between the two alkaloids is that *hydrastinine* lacks the exciting effect of *hydrastine* on the spinal cord, as well as its paralyzing effect on muscular tissue in general. According to Cushny, small doses of either alkaloid slow the heart somewhat by stimulation of the vagus center in the medulla; this appears to conflict with the statement of others that therapeutic doses tend to increase the cardiac rate. Upon the medullary centers, *hydrastinine* acts like *hydrastine*, causing, *e.g.*, acceleration of the res-

piration in small amounts and paralysis in toxic doses. According to Paldrock, the renal vessels are dilated by *hydrastinine*, in contrast with the constricted vessels elsewhere. *Hydrastinine* excites uterine contractions in the same way as the parent alkaloid, but acts more powerfully, almost rivaling *ergot* (Kehrer).

There is an appreciable difference between the actions of *hydrastis* and of *ergot*, as *hydrastis* does not produce tetanic contractions of the uterine muscle. Animals respond promptly to *ergotin* and *hydrastis* hypodermically. Suggestion that *hydrastis* and *ergotin* be employed together, to avoid the great increase of intra-uterine tension and tetanic contractions caused by *ergot*. Fellner (Archiv f. Gynäk., Bd. lxxviii, Hft. 3, 1906).

Uterine contractions are excited by *hydrastis* and *ergot* even though the uterine nerves are absolutely cut off. *Hydrastine* and *hydrastinine* are much stronger than *hydrastis*. *Hydrastine*, *hydrastinine*, *styptol*, and *stypticin* all have a perceptible action in a dilution of $\frac{1}{200000}$, and are of practically the same value. The action occurs in all stages of development of the uterine muscle, from birth on through all stages of pregnancy. *Berberine* and *berberinine* have no action on the uterus. Uterine contractions from *hydrastis* or *ergot* follow independently of blood-vessel contraction. The close resemblance between *ergot*, *hydrastis* and *cotarine* preparations speaks against the use of the last two in hemorrhage during pregnancy. Kehrer (Monats. f. Geb. und Gynäk., Bd. xxvi, H. 5, 1908).

CONTRAINDICATIONS. — According to Marini, *hydrastis* slackens the cardiac beats when given in large amounts; in such doses it is therefore contraindicated in persons with a permanently slow pulse and in chronic cardiac affections.

POISONING.—The symptoms of poisoning by hydrastis are largely those of circulatory and respiratory depression, the convulsive apparently not having been noticeable in the cases so far recorded. Miodowski reports a case in an elderly man who had been ordered 20 drops of the fluid-extract three times daily on account of bronchitis. After two doses there appeared dyspnea, lividity, inspiratory râles, whistling expiration, and feeble heart action. Gradual improvement took place after the use of stimulants (**ether, wine, coffee, mustard paper,** etc.). The symptoms were presumably due to the heart weakness, with secondary congestion and edema of the lungs. No fatal cases of poisoning by hydrastis have been reported.

Case of poisoning due to fluidextract of hydrastis. A girl of 22 years, because of marked uterine hemorrhage following abortion, took about $3\frac{1}{2}$ drams (14 Gm.) of this preparation. She soon developed nausea, vertigo, faintness, restlessness and headache; and later, hallucinations, dyspnea, and precordial oppression. A few hours after, the patient vomited a thick, dark-green liquid. There was great weakness, pallor, and some cyanosis; the heart sounds were weak, the pulse rate 46, and the temperature 97° F. (36.1° C.). The symptoms improved, and the patient was discharged cured after five days. Friedeberg (Centralbl. f. innere Med., Oct. 18, 1902).

THERAPEUTICS.—Subacute or chronic inflammation and lowered tone of mucous membranes constitute an indication for the local use of hydrastis, to which marked benefit in such affections has been ascribed. Among the conditions in which its employment is suitable are **chronic gastrointestinal catarrh**, especially that resulting from continued alco-

holic indulgence, **subacute catarrh of the biliary passages** causing jaundice, and similar affections of the nasal, urethral, cystic, uterine, and vaginal mucosæ. Sängner recommends the fluidextract administered internally in doses of 20 or 30 drops four times a day to relieve **cough** in **pulmonary tuberculosis**. The drug has also been used with asserted marked and persistent benefit in **chronic bronchitis** with profuse expectoration. H. M. Jones reported excellent results from application of the tincture as a cervical dressing on the vaginal tampon, or its addition to the water used for a hot douche, in **cervical erosion** and **chronic endometritis**. In **gonorrheal infection of the vagina** in the female, and **leucorrhea** in general, irrigation with an infusion of 2 drams (8 Gm.) of powdered hydrastis in a pint (500 c.c.) of water has been recommended. **Gonococcal urethritis** in the male may be similarly treated in its subacute stage, by injections of 0.25 to 0.5 per cent. hydrastine hydrochloride or the fluidextract (10 to 20 minims to the ounce of mucilage—Wood) directly into the canal, with simultaneous use of the fluidextract by mouth. In **spermatorrhea**, instillations of hydrastine are frequently beneficial. **Vomiting of pregnancy** is another condition in which hydrastis is asserted to have given good results. In **mucous or ulcerative colitis**, bowel irrigations with 1.5 to 5 per cent. dilutions of the fluidextract or glycerite of hydrastis have proven very serviceable. In the **gastric crises of tabes dorsalis** a mixture of the fluidextracts of hydrastis and belladonna with chloral hydrate is useful to keep up the anodyne effect of morphine, while in **retention** and **incontinence of urine** in the same dis-

ease a combination of hydrastis with belladonna or hyoscyamus will likewise yield good results (Collins and Zabriskie).

Among the various expectorants, hydrastine hydrochloride is one of the best. It possesses a remarkable effect in loosening tenacious mucus and aiding its expectoration, in **chronic bronchitis** especially. The author administers it in doses of $\frac{1}{2}$ to 1 grain (0.032 to 0.065 Gm.) three or four times a day. M. Sanger (Wiener klin. Rundschau, Nos. 19-20, 1902).

In **capillary hemorrhages** the dose of hydrastine hydrochloride is $\frac{1}{8}$ to $\frac{1}{2}$ grain (0.01 to 0.03 Gm.), repeated every two hours until effect. Its action in these cases is too slow for emergencies, and on such occasions other remedies must be relied on. J. M. French (Med. Council, June, 1908).

In **atonic dyspepsia** the bitter stomachic influence of berberine is often of considerable value, though the more marked stimulant action of hydrastine on the spinal cord would seem to be an advantage in favor of the administration of the whole drug—hydrastis—the action of which appears to resemble that of nux vomica more than does that of berberine.

A second group of conditions in which hydrastis has been extensively used is that having as common manifestation **hemorrhage**, which hydrastis, and especially hydrastinine, are considered capable of relieving through constriction of the vessels. The drug is rather slowly absorbed and cannot be expected to give results when given by mouth in emergency cases. On the other hand as a preventive, *e.g.*, in **epistaxis**, Kohn found 10-drop doses of the fluidextract every two or three hours very effective. Similarly, in **hemoptysis** Koniger recommends 20- to 30- drop doses

several times daily, and in the **intestinal hemorrhage** of **typhoid fever** and **dysentery** the drug has also been used. To secure a prompt effect in rebellious epistaxis, $\frac{1}{4}$ grain (0.015 Gm.) of hydrastinine hydrochloride should be given subcutaneously.

It is chiefly in gynecological conditions, however, that hydrastis and its derivatives are employed. In **dysmenorrhea**, whatever be its cause, administration of 20 to 30 minims (1.25 to 2 c.c.) of hydrastis fluidextract in black coffee, beginning eight to ten days before the expected period, together with suitable baths and the drinking of saline waters, will prove beneficial (Montgomery). Similarly, in **menorrhagia**, hydrastis or one of the related alkaloids may be of value. Fuchs found 20 minims (1.25 c.c.) of the fluidextract four times daily effective in menorrhagia associated with **uterine fibromyoma**, while Jones considers the drug of special value in hemorrhages of the **menopause**. Porak and Kallmorgen recommend hydrastinine in preference to the crude drug, the latter giving the alkaloid in $\frac{1}{2}$ -grain (0.03 Gm.) pills; in cases of **functional menorrhagia**, 2 of these pills are ordered taken daily for a day or two before the expected period, and when the flow commences 3 pills a day are used until it ceases. In **hemorrhage after abortion**, and in that due to lesions of the appendages, hydrastinine usually proved efficacious in Kallmorgen's hands; in the hemorrhage of uterine cancer, however, it has been repeatedly tried without result. Herzfeld, in hemorrhages arising from uterine deviations, serious abnormal puerperal conditions, and gonococcal infection, found hydrastine superior to ergot; it

controlled the bleeding within a few days at most. The dose used was 0.025 Gm. ($\frac{1}{2}$ grain) four times daily.

Berberine is indicated as a simple bitter wherever there is a lack of tonicity of the intestines, with constipation or passive relaxation, and in **enlargement of the spleen**, where it is well used in conjunction with quinine. In **menorrhagia**, **metrorrhagia**, and **subinvolution of the uterus**, it is inferior to hydrastinine. In **malaria** as much as 15 grains (1 Gm.) may be required daily, in divided doses; but even here $\frac{1}{6}$ grain (0.01 Gm.) every waking hour is usually sufficient. It is much more effective to keep the blood saturated with the remedy given in small doses than to give a single large dose.

Hydrastine hydrochloride, 3 grains to the ounce (0.2 Gm. to 30 c.c.) of glycerin, is useful in some cases of **granular conjunctivitis**. It is also used in **nasal catarrh** and **leucorrhea**, both internally and locally. When combined with strychnine and capsicum, it is the best substitute for alcohol. The specific use of hydrastinine is in restraining **uterine hemorrhage**. It is slower in its action than ergot, but more lasting in its effects. In **hemoptysis** it should be continued for a week or more after the hemorrhage has ceased. J. M. French (Amer. Jour. Clin. Med., Aug., 1906).

Hydrastinine hydrochloride used to check bleeding of the oozing, long-continued type, with uniformly satisfactory results. Report of cases of **uterine hemorrhage**, **hematemesis**, and **vicarious epistaxis** in which good results followed use of hydrastinine by mouth. T. Anderson (Amer. Jour. Clin. Med., Sept., 1908).

In the preventive treatment of **hemoptysis**—tuberculous patients with high blood-pressure, at the menopause, etc.—bi- or tri-weekly injections of 0.04 to 0.05 Gm. ($\frac{1}{4}$ to $\frac{1}{2}$ grain) of hydrastinine hydrochloride may be given. In established hemoptysis, the former dose should be injected once and even twice daily

for several days, until the hemoptysis ceases. Where its use is protracted strychnine or camphorated oil injections should be given in conjunction with it, to prevent an excessive reduction of blood-pressure. F. Barbary (Gaz. méd. belge, Apr. 7, 1910).

Synthetic hydrastinine tried in uncomplicated **uterine hemorrhage** and found very satisfactory. It acts particularly well when given prophylactically for some time before hemorrhage begins, and in cases with virgin uteri. Hemorrhage during pregnancy is not to be treated by this drug because of the uterine contractions it produces. It is more effective and palatable than hydrastis, and much cheaper. H. Offergeld (Berl. klin. Woch., Jan. 13, 1913).

Hydrastinine should be used when a direct contracting action upon the arteries of the uterus is required, and when no gross lesions or new growths exist, as in such cases failure may be looked for uniformly. It is especially valuable in the **menorrhagias** taken prophylactically before the menstrual period, twice daily in small dosage, and in larger amount three times daily during menstruation. The period of bleeding is shortened, while tendency to clot formation is overcome. The author has also used it subcutaneously in some 30 cases, especially after operation, as curetment, etc. No local irritation was ever observed. By the mouth the dose ranged from $\frac{1}{4}$ to 3 grains (0.048 to 0.2 Gm.), sometimes even 4 grains (0.26 Gm.) twice a day. Smaller doses, $\frac{1}{6}$ to $\frac{1}{4}$ grain (0.01 to 0.016 Gm.), repeated at half-hour to one-hour intervals, usually elicit the desired action as well. H. Walther (Münch. med. Woch., April 1, 1913).

Bossi many years ago recommended large doses of fluidextract of hydrastis—150 to 200 drops in 3 or 4 doses—as an immediate curative agent in post-partum hemorrhage, and also used the drug as a prophylactic against hemorrhage in cases of hy-

dramnios, uterine inertia, etc. Subsequent experience, however, did not effectually support his claims, and there appears to be no ground for advising the use of hydrastis in preference to ergot. While miscarriage can be produced in dogs and rabbits with hydrastine (Archangelski), the oxytocic properties of hydrastis in the human subject do not seem to be very marked, though von Styrk saw miscarriage in the fourth month take place on the third day of administration of 100 drops of tincture of hydrastis for severe cervical catarrh. Marini states that as an oxytocic hydrastis is not so rapid in action as quinine. Faber, administering hydrastine hypodermically to 13 pregnant women, found the drug to bring on uterine contractions in 12 instances.

Cruse found hydrastis useful in the treatment of **night sweats**; he administered 30 minims (2 c.c.) of the fluid-extract at a dose.

Petty used hydrastine or berberine with petroleum emulsion in the **chronic gastric catarrh of alcoholics**, with excellent results, but later gave these up in favor of a dilute solution of ichthyol, which, disguised with cinnamon water, proved still more effective. According to Marini, hydrastis almost constantly exerts a favorable effect on **hemorrhoids**, whether internal or external; irreducible piles can be easily returned after its use. Wegele applies the fluidextract externally for bleeding in the same condition.

In **stomatitis** and **follicular pharyngitis** the glycerite or fluidextract of hydrastis has proven serviceable when locally applied. Likewise in **sluggish ulcerations**, **necrotic cancer-**

ous areas, and **chancroids**, dressings of hydrastis exert a favorable influence. In **catarrhal conjunctivitis** and for the general purpose of stimulating the conjunctiva, instillation of a 0.1 to 0.2 per cent. solution of hydrastine hydrochloride has been recommended.

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HYDROA. See DERMATITIS (DERMATITIS HERPETIFORMIS).

HYDROCELE. See PENIS AND TESTICLES, DISEASES AND INJURIES OF.

HYDROCEPHALUS. See HEAD AND BRAIN, SURGICAL DISORDERS OF

HYDROCHLORIC ACID.—Hydrochloric acid (muriatic acid; chlorhydric acid; hydrogen chloride) is generally seen as a clear, colorless, pungent, fuming liquid having an intensely acid odor and taste. This does not represent, however, HCl alone, but a solution of it in water, pure hydrogen chloride being an invisible gaseous compound, which is given off from the solution when it is exposed to the air, the visible fumes being the result of union and condensation of the acid gas with water vapor. A saturated or "fuming" hydrochloric acid solution contains about 37 to 40 per cent. by weight of HCl gas dissolved in the water, while the ordinary "C. P." or pharmacopeial acid contains 31.9 per cent. The specific gravity of the latter variety is approximately 1.16. Commercial hydrochloric acid is of about the same strength, but is yellowish in color, owing to the presence of iron from the containers used in its manufacture as well as free chlorine, and also sometimes embodies arsenic to

the amount of 0.25 per cent. Hydrochloric acid is miscible in all proportions with alcohol and water. Upon diluting the concentrated acid with 2 volumes of water its pungent fumes and odor are no longer set free.

PHYSIOLOGICAL ACTION. —

In common with other mineral acids, hydrochloric acid in concentrated form is a decided caustic. Its great affinity for water and its tendency to combine with the alkaline bases cause it to attack the living tissues energetically and induce destructive changes. Its caustic action is not as powerful, however, as that of sulphuric or nitric acid, and when applied to the skin it leads to blister formation rather than actual necrosis. Whitish stains are produced when the strong acid comes into contact with a mucous membrane, and here it may, on the contrary, cause sloughing of tissue. Hydrochloric acid, as might be expected from its gaseous nature and volatility, possesses considerable diffusive power and passes readily through animal membranes. Ingested acid which escapes union with the protein bases in the stomach tends to diffuse into the blood and there form salts with the bases of that fluid, setting free the weaker acids. This tends to decrease the alkalinity of the blood and increase the acidity of the urine. It is to be borne in mind, however, that there exists in the body a mechanism having for its purpose to maintain the normal alkalinity of the blood. When an excess of acid enters the system, the normal transformation of ammonia into urea fails to take place as completely as usual, the ammonia uniting with the acid to form a salt and being excreted in combination with it. Furthermore,

acid salts produced through partial neutralization of the acid act as diuretics, promoting their own elimination. A considerable excess of acid is therefore required to threaten seriously the alkalinity of the blood.

When ingested in dilute form and in medicinal doses, the first action of hydrochloric acid is to augment the salivary secretion. It is a general law that acids applied topically check the production of acid secretions from glands, but increase the flow of alkaline secretions. Besides producing a direct effect of this kind, hydrochloric acid also acts reflexly through the cerebrospinal nerves supplying the salivary glands. On reaching the stomach the acid combines with the proteins present there to form acid albuminates (acid metaproteins). Hydrochloric acid is normally an ingredient of the gastric juice (0.2 per cent.). It aids in the transformation of pepsinogen into pepsin, and also assists the pepsin to digest the protein food-principles.

PREPARATIONS AND DOSE.—

Acidum hydrochloricum, U. S. P. (hydrochloric acid), of 31.9 per cent. strength. Used to prepare the diluted and other acids.

Acidum hydrochloricum dilutum, U. S. P. (diluted hydrochloric acid), made by mixing 100 parts by weight of the preceding with 219 parts of distilled water, and containing 10 per cent. by weight of hydrochloric acid gas. Its specific gravity is about 1.05. It is odorless and does not fume in the air. Dose, 5 to 60 minims (0.3 to 4 c.c.).

Betaine hydrochloride (acidol) [$C_5H_{11}NO_2.HCl$], unofficial, appearing in the form of colorless crystals or made into tablets, freely soluble

in water, and containing 23.8 per cent. of pure hydrochloric acid. This acid is gradually set free when the compound is dissolved in water. Dose, 8 grains (0.5 Gm.); this equals about 18 minims of 10 per cent. hydrochloric acid.

MODES OF ADMINISTRATION.—Hydrochloric acid should always be ordered freely diluted with water (or in lemonade or beef juice), and should be taken through a glass tube or straw, introduced far back in the mouth, in order that contact of the acid with the teeth may be as much as possible avoided. As this object is not always completely attained, various other, more safe modes of introduction have been devised. Aaron recommends the ingestion of the usual 15-minim (1 c.c.) doses of the dilute acid in large double-bottomed capsules, made by inserting the top of an "O" capsule into the bottom of an "OO" capsule. Water is, of course, to be subsequently taken as diluent. A more widely used procedure is to employ betaine hydrochloride or acidol, a solid substance which gives off the acid slowly when dissolved in water.

The dose of dilute hydrochloric acid for stomachic purposes is 5 to 10 minims (0.3 to 0.6 c.c.) and the time of administration usually before meals. Larger amounts, employed to assist digestion or obviate fermentation, are given after meals, frequently in divided doses. Boardman Reed finds even 4 or 5 minims (0.25 or 0.3 c.c.) of the acid, added to half a goblet of water, which is taken in small sips at frequent intervals during an hour or an hour and a half after meals, sufficient to stimulate the gastric glands. In cases of com-

plete or nearly complete anacidity the sipping is begun immediately after the meal; otherwise, not until half an hour after it, in order to give time for salivary digestion of the starchy portion of the food. This gradual method of administering the acid avoids the burning of the stomach witnessed in intolerant cases. Where necessary, the dose is gradually increased to 10 or 20 minims (0.6 or 1.25 c.c.).

According to Huchard, hydrochloric acid treatment should not be continued for more than three or four weeks at a stretch, an intermission of two weeks being then made before resumption of the remedy.

Administration of hydrochloric acid aids in bringing about a normal condition of duodenal digestion. The author's usual plan is to give 20 drops of the diluted acid in 2 ounces (60 c.c.) of water fifteen minutes before the meal. It should always be taken through a glass tube and the mouth afterward rinsed with a weak solution of sodium carbonate. For improving the appetite the acid is best given in doses of 10 to 20 drops diluted in 3 ounces (90 c.c.) of water on an empty stomach before meals. The author has observed cases of anacidity in which the acid caused gastric distress. One patient, a decided neuropath, could detect 6 drops of it when surreptitiously given. J. C. Hemmeter (*Amer. Med.*, April 27, 1901).

INCOMPATIBILITIES.—Hydrochloric acid is incompatible with alkalies, salts of silver and lead, oxides, chlorates, and permanganates.

CONTRAINDICATIONS.—Hydrochloric acid is generally regarded as contraindicated in all forms of gastric hyperacidity and hyperesthesia. Cohnheim and others have advised, however, that in hyper-

acidity accompanied by excessive motor activity of the stomach, in cases where alkalies fail to relieve, the administration of the acid with or after meals be tried, on the theory that the hyperacidity in these cases is actually the result of a too rapid passage of the food from the stomach into the intestine, which can be controlled through the regulating influence of hydrochloric acid in the pyloric region, both by softening the connective tissue and by dissolving and acidifying the proteins themselves. In addition, it acts as an intragastric disinfectant, preventing or arresting abnormal fermentation of the food by destroying any microorganisms present. It is said to prevent the lactic fermentation in 0.1 per cent. dilution (Cushny). Finally, during digestion hydrochloric acid largely governs the state of occlusion or patency of the pylorus, the sphincter of which relaxes when the food in the stomach has become saturated with the acid, the latter being therefore present in excess and in an uncombined state. It is considered a possibility that upon reaching the duodenum the acid reflexly excites the flow of pancreatic juice; it is well known, moreover, to govern the production of the hormone secretion.

In cases of hypoacidity, hydrochloric acid, artificially administered, will stimulate gastric secretion; even in anacidity or achylia gastrica, if the glands have any secretory power left, the acid will rouse them to activity. The reflex effect of hydrochloric acid on pancreatic activity, as well as its chemical action in the duodenum, whereby carbon-dioxide bubbles are set free through neutralization by the alkalies present and break up the food

into finer particles, probably accounts for the fact that even small doses of the acid may suffice to assist digestion where it is impaired (Wegele).

Experiments on dogs showing that when hydrochloric acid is given before feeding it has no more influence on the gastric secretion than water alone. When given at the beginning of secretory activity, however, the latter persisted longer than after water alone. F. Heinsheimer (*Archiv f. Verdauungs-Krankh.*, Bd. xii, Nu. 2, 1906).

When von Loghen fed hydrochloric acid to rabbits, he found he could control the precipitation of insoluble sodium urate thereby. The author points out, however, that the solubility of urates depends upon the sodium ion concentration of the fluid, and if one accepts the solvent action of hydrochloric acid one must assume that the sodium ion content of the body fluids is reduced by it. In his own experiments the sodium content in hydrochloric-acid-fed animals was not lessened, but increased. Therefore, a different explanation must be advanced for the possible therapeutic benefits from hydrochloric acid in rabbits with artificial deposits of urates. Staal (*Zeitsch. f. phys. Chem.*, Bd. ii, S. 97, 1908).

POISONING.—Ingested in concentrated form, hydrochloric acid destroys the mucous membrane of the mouth, epiglottis, esophagus, and stomach; and violent gastroenteritis attended with very alarming symptoms ensues. Pain is present throughout the digestive tract, and vomiting of coffee-ground matter, blood, or even portions of the mucous membrane occurs. With this are associated a feeble pulse and clammy skin. Diarrhea and cramps in the lower extremities may be present, and the urine may show albumin, casts, and blood-cells. Death, when it occurs as

an immediate result of the ingestion of acid, generally takes place from shock due to the extensive destruction of tissue, followed by collapse. If the case is seen very early, the characteristic odor of the acid may be detected in the breath, and a whitish, pungent vapor may be seen issuing from the mouth. This acid is especially likely, owing to its frequently "fuming" condition when taken, to cause spasm or edema of the glottis, which may result in death by asphyxia.

Though it produces a temporary reddish or greenish stain on clothing, hydrochloric acid does not discolor the skin. Cases of ingestion of the acid have been reported in which the mucous membrane of the mouth showed no injury. More typically, however, the epithelial covering of the mouth and esophagus is for the most part lost, or in places adherent in the form of grayish shreds. The mucosa is reddened and swollen and may show a network of injected blood-vessels. In the stomach there is usually found strongly acid fluid of a coffee-ground color the filtrate from which will produce a heavy, white precipitate of silver chloride when added to a solution of silver nitrate. The bared submucous tissues are colored black, any persisting mucous membrane is dull and swollen, and the muscularis and peritoneum, if revealed, present a cooked appearance. In a case referred to by Puppe the duodenum and upper jejunum showed a wide-meshed network of black streaks, corresponding to the summits of the folds of the valvulae conniventes, laid bare and infiltrated with blood, the intervening spaces, better protected from the acid, pre-

serving a grayish-yellow color. In common with other strong acids, hydrochloric shrinks and renders hard and brittle all tissues, including blood, with which it comes in contact. This distinguishes its effects from the swollen, soft, and slimy appearance produced by alkalies.

Fatty degeneration of various viscera has sometimes been found in cases of mineral acid poisoning that have survived only a few days.

The average fatal dose of concentrated hydrochloric acid may be roughly stated as one tablespoonful, though a much smaller amount may prove lethal if the fumes reach the larynx to any considerable extent. On the other hand, recovery has taken place after ingestion of an ounce of the acid (Wood). Death, if due to the immediate effects, occurs generally in about twenty-four hours, though in some cases the period of survival has been limited to a few hours. Secondary fatal results not infrequently follow as long as several months after the poisoning, from stricture of the esophagus or impaired gastric digestion, with consequent progressive inanition.

Case of hematemesis in a young woman, apparently due to simple ulcer of the stomach. In a few days diphtheritic patches were noted in the pharynx, from which a short *Bacillus diphtheriae* was cultivated; then a long false membrane was coughed up, presumably from the trachea and bronchi. After a fortnight it was found that all the lesions were due to hydrochloric acid, which the patient had drunk. Le Gendre (Presse méd., June 23, 1900).

Case of hydrochloric acid poisoning in a child 2½ years old. There was no staining or erosion of lips, tongue, or mouth. The vomit did not have an acid reaction. Calcined

magnesia was at once administered; also a starch enema with 10 minims (0.6 c.c.) of laudanum, strychnine injections, and brandy by rectum. The child died six hours after taking the acid. Eight or 10 small perforations were found in the lower part of the stomach, which contained dark blood; there were 8 or 10 ounces of blood in the peritoneal cavity; the entire gastric mucosa was blackened and eroded, as was the duodenum for about 2 inches from the pylorus. The wall of the stomach was so thin and rotten that even the softest tube would almost certainly have perforated any part of it. W. Billington (Birmingham Med. Rev., Oct., 1900).

On the ninth day following ingestion of a poisonous quantity of hydrochloric acid, the mucous membrane of the esophagus was expelled in a tubular form. Three months later death took place; hypertrophy of the pylorus, with consequent stenosis, was found. The prognosis is not always bad, as several recorded cases show. In this case, in addition to the dense pyloric scar, there was thickening of the entire gastric musculature. H. Strauss (Berliner klin. Woch., Jan. 11, 1904).

Treatment of Poisoning.—In these cases the use of the stomach-tube is contraindicated, unless the patient be seen much earlier than is usually the case. The chemical antidotes are the **alkalies and their carbonates**, especially **magnesia**; otherwise, **lime**, **prepared chalk** (wall-scrapings, if nothing better), **washing or baking soda**, **soapsuds**, and even **dilute ammonia**, all to be administered in an ample amount of water or milk. The administration of **albumin**, **eggs**, **gum arabic** or other **mucilage**, **milk**, **oils**, **barley water**, etc., will act mechanically to protect and soothe the corroded tissues. Even after thorough neutralization of the poison it is best to give **milk** and very **dilute alkaline**

solutions for some hours (Holland). **Opium** by mouth or **morphine** by hypodermic injection will be useful to relieve the pain and irritation. **Ice** may also be employed. To counteract the great depression present in these cases, **intravenous injections of ammonia** may be made, hypodermic injections of **strychnine**, **atropine**, **camphorated oil**, **digitalis**, etc., given, and **nutrient and stimulant enemata** administered.

Demulcents in solid form, allowed to dissolve in the mouth, will bring much relief from the pain of oral and pharyngeal inflammation (H. C. Wood, Jr.).

Case of ingestion of $1\frac{1}{2}$ ounces (45 c.c.) of concentrated hydrochloric acid. Milk, promptly given, was vomited at once in large curds. Twenty-five minutes after the accident there was administered **sodium bicarbonate**, *ad libitum*, in solution, and **lavage of the stomach** was done, using about 1 ounce (30 Gm.) of sodium bicarbonate in a quart (liter) of water. This could not be withdrawn and the tube was found plugged with thick mucus. Another attempt to wash out the stomach was futile, either because of mucus or possibly perforation due to the acid. Apomorphine hydrochloride, $\frac{1}{10}$ grain (0.0065 Gm.), failed to produce emesis in five minutes, and was repeated, also without effect. Still conscious and complaining of pain, the patient was given hypodermically **morphine sulphate**, $\frac{1}{4}$ grain (0.016 Gm.), and **atropine sulphate**, $\frac{1}{100}$ grain (0.00065 Gm.); more sodium bicarbonate was administered. She complained of thirst, mucus flowed freely from her mouth, and swallowing was difficult. In spite of stimulation she went into collapse about one hour and a half after taking the acid, developed pulmonary edema, and died of respiratory failure in about five hours. Wollheim (Amer. Jour. of Surg., Jan., 1907).

Under certain circumstances **operative intervention** is indicated, either in the period immediately following the ingestion of the acid or as a secondary procedure where difficulty of alimentation, due to stenosis or destructive changes in the gastrointestinal tract, places the patient's life in jeopardy.

Report of 4 cases of ulceration of the esophagus and stomach due to strong hydrochloric acid. The first case showed enormous dilatation of the stomach after accidental poisoning by strong hydrochloric acid eight months previously. Complete relief was obtained by **Loreta's operation**. Ulceration of the esophagus and pharynx leads to infection of the air passages in these cases, either through the lymphatics or the trachea.

The patient should receive no food, liquid or solid, by the mouth for several weeks, that is, until there is good reason to believe that the injuries have completely healed. When the injuries are serious (as is usual) an operation should be performed within a few days after the poisoning—the sooner, the better. The pyloric portion of the stomach is the part most seriously injured. A **gastroenterostomy** should be performed and two tubes introduced through the abdominal wound, one entering the intestine through the new opening and the other remaining in the stomach; through one the patient can be fed and through the other the stomach irrigated.

The **mouth** should be freely washed out with warm **boric lotion**. Dirty **teeth** should be **cleansed**, diseased teeth should be treated with pure carbolic acid or by extraction, and suppurating alveoli attended to, under local or gas anesthesia if necessary.

The **pharynx** should be **sprayed** frequently with hot **boric lotion** and twice a day dusted with a little **iodoform powder** through a puff.

As soon as the patient can swallow without pain he should be allowed **hot water** or **hot neutral saline ad libitum** and be encouraged to take it. The hot water swallowed should be allowed to escape by the short gastrostomy tube, so that it will tend to wash out the stomach also. In addition, after each meal given by the gastrojejunal tube, the **stomach** should be **washed out with hot water** through the gastric tube. C. B. Keetley (Lancet, Nov. 16, 1901).

Report of 3 cases of ingestion of mineral acids in which, although the stomach was found more or less extensively cauterized at operation, the esophagus was but slightly or not at all injured. Early operative intervention is desirable only where vomiting does not promptly occur and, in addition, neutralizing fluids cannot for some reason be administered or the stomach washed out. **Gastrotomy, evacuation, and irrigation** are then indicated. In other cases operation is not justified unless copious and repeated bloody vomiting later appears, or there is reason to believe perforation imminent. Under these conditions, if there is necrosis of the gastric wall, the sphacelated area should be brought up to the exterior, and gastric rest and alimentation secured by means of a **jejunostomy**. If the area cannot be exteriorized, **resection** is necessary. Where there is no necrosis, the stomach being hyperemic and bluish, **jejunostomy** by the **Eiselsberg-Witzel technique** should be practised. On the whole, the occasion for early intervention is only infrequently presented. Oftener, a secondary operation is necessary because of continued gastric intolerance; this operation should not be delayed after it is plain that serious injury to the stomach has occurred. Where diffuse cicatricial changes are found, or are about to become established, jejunostomy is the procedure of choice, though **gastroenterostomy** may prove sufficient in some instances. Exclusive feeding through

the jejunostomy opening will often lead to such improvement that posterior gastroenterostomy and restoration of oral feeding can later be effected. Where the cicatricial changes are found limited to the pyloric region, the stomach being dilated, gastroenterostomy is alone necessary. X. Delore and L. Arnaud (*Revue de chir.*, April, 1913).

THERAPEUTICS. — Internally, hydrochloric acid is used chiefly in gastrointestinal disorders. In **atonic dyspepsia** the dilute acid may be given, either alone or combined with some preparation of pepsin, immediately *after* meals. In **achylia gastrica** with absence of both acid and pepsin from the stomach, Wegele uses the following formula:—

℞ *Acidi hydrochlorici*
diluti,
Pepsiniāā ʒiiss (10 Gm.).
Aquæ sterilisatæ fʒiij (100 Gm.).

M. Sig.: One teaspoonful in a wineglassful of water to be taken with the meal through a glass tube.

Kaufmann points out the fact that hydrochloric acid often proves a better appetizer than the bitter tonics themselves. Where after subsidence of an attack of **acute gastritis** there is anorexia and a feeling of pressure or discomfort in the stomach region, the following combination will be found of value (Bassler):—

℞ *Acidi hydrochlorici*
diluti fʒj (30 c.c.).
Strychninæ sulphatis. gr. $\frac{1}{2}$ (0.05 Gm.).
Elixir gentianæ (N.
F.)q. s. ad fʒiv (120 c.c.).

M. Sig.: One teaspoonful in a half-glassful of water before meals through a glass tube.

If the acid provokes pain on the empty stomach in these cases, it should be given after the meals, and well diluted.

In **chronic gastritis** Leube and Ewald recommend the administration of hydrochloric acid in divided doses, beginning one-half hour after meals. The total amount—from 10 to 60 minims (0.6 to 4 c.c.), according to individual preference—is placed in a small glassful of water and taken in three doses at fifteen-minute intervals. Combinations with other drugs, such as the following (Kemp), may be used:—

℞ *Acidi hydrochlorici*
diluti,
Tincturæ cinchonæ
compositæāā fʒss (16 c.c.).
Tincturæ nucis vomicæ. fʒiij (12 c.c.).
Aquæ sterilisatæ, q. s.
ad fʒiv (125 c.c.).

M. Sig.: One to two drams in water one-half hour after meals.

Gastric lavage in the same affection may be performed with a solution of 3 fluidrams (12 c.c.) of the dilute acid in 2 quarts (2000 c.c.) of water; besides removing mucus, this will tend to excite hydrochloric acid secretion (Bassler). In **gastric cancer** digestion can frequently be improved by a combination of hydrochloric acid and nux vomica with condurango (15 to 60 minims, or 1 to 4 c.c., of the fluidextract at a dose) and gentian. In this disorder lavage with a solution of the acid may be of great value for purposes of intragastric disinfection. Other conditions indicating the use of hydrochloric acid are **nervous dyspepsia** with subacidity, the subacidity accompanying **chlorosis**, and **chronic gastric dilatation** with subacidity, stagnation, and abnormal food fermentation. Croftan and others have seen good results from the systematic administration of hydrochloric acid in **pernicious anemia**. Martin finds that if these patients sip

5 to 10 drops of the dilute acid in a wineglassful of water in the course of ten minutes after taking food, digestion is frequently bettered and diarrhea arrested. In **chronic heart disease** with muscular insufficiency liberal amounts of hydrochloric acid, well diluted, may be of some assistance in alleviating symptoms referable to the digestive tract (Williamson), though the more direct causal treatment with heart tonics is not to be lost sight of. In subacidity accompanying **hepatic cirrhosis** hydrochloric acid ingested after meals will not infrequently bring about marked subjective relief.

The writer gave 20 minims (1.25 c.c.) of dilute hydrochloric acid in 90 c.c. (3 ounces) of water, two or three times at fifteen-minute intervals, after an Ewald test-breakfast. One hour after the meal the total acidity was always found increased, and in 3 of the 4 tests free hydrochloric acid was present in appreciable amounts. From 15 to 25 minims (1 to 1.6 c.c.) of hydrochloric acid were given in 3 ounces (90 c.c.) of water three times within an hour after the ingestion of a large meat sandwich and 10 ounces (300 c.c.) of water. Nine tests were made. In sixty to seventy minutes after the meal the total acidity of the gastric contents was always found increased, but free hydrochloric acid was never present. Long-continued use of large doses (45 drops three times daily) of hydrochloric acid diminished the total acidity. The author believes the acid to have a depressing influence on the gastric acidity which is not generally recognized. Peptic digestion, however, is accelerated by its use, although in certain conditions large doses in some manner retard peptic digestion. The acid did not seem to stimulate gastric peristalsis to any marked extent. R. F. Chase (Boston Med. and Surg. Jour., Sept. 7, 1905).

Hydrochloric acid is very useful in a large proportion of cases of deficient secretion; those without symptoms, however, do not require any treatment, and the severer cases cannot be influenced by hydrochloric acid alone. The writer gives from 5 to 10 drops of dilute hydrochloric acid several times a day. This small amount has little direct influence on the digestion, but stimulates by reflex action the entire digestive process. Combination of hydrochloric acid with pepsin or other substances is liable to annul the action of the acid completely. E. Fuld (Therap. Monats., Nov., 1910).

Alkiewicz has used well-diluted hydrochloric acid with success as a remedy for **nausea** and **vomiting**, including that of **cholera morbus** and certain infectious diseases, the **vomiting of pregnancy**, and persistent emesis in cases of maldigestion of food in the stomach. The vomiting of food in **neurasthenic** patients, unaccompanied by epigastric burning or soreness, was always controlled, in Tournier's experience, by full doses of the acid. Likewise, in **gastric catarrh** of **alcoholic** origin, vomiting, as well as the sensation of weight and distention after meals and the insomnia, is relieved by the ingestion of hydrochloric acid.

In **acute intestinal catarrh**, provided there be no nausea, dilute hydrochloric acid in doses of 10 minims (0.6 c.c.) three times daily may prove useful as an adjunct to intestinal antiseptics (Kemp), tending to overcome abnormal fermentation in the upper segments of the alimentary tract. Tournier points out that **lienteric diarrhea**, associated with marked hypoacidity, but few or no gastric symptoms, yields in four or five days to generous amounts of the dilute acid, taken in 3 divided doses at half-

hourly intervals after each meal. In **typhoid fever** large doses of the acid were at one time recommended as a specific measure. The only legitimate uses of the drug, however, are to increase the salivary and buccal mucous secretions,—thus tending to prevent or relieve dryness of the mouth and the accumulation of sor-des,—and more particularly to make good the deficiency of acid in the gastric juice, well known to exist in this and other fevers, *e.g.*, **scarlatina**. It may be given either as a special dose before each meal in water, or added in small amount—20 minims (1.2 c.c.)—to the patient's drinking-water. In cases of **pulmonary tuberculosis** with chronic indigestion, gastric hypoacidity is usually present, and the administration of hydrochloric acid with or without pepsin will be found correspondingly useful; it is sometimes recommended to intermit the drug from time to time. **Oxaluria** is a condition in which hydrochloric acid has yielded good results.

In cases of **poisoning by alkalis** hydrochloric acid, well diluted, may be used as an antidote, though vinegar and lemon juice are more likely to be at hand, and sulphuric acid is often preferable to it, the salts formed with hydrochloric acid being usually soluble and somewhat irritating.

Skin affections symptomatic of imperfect digestion and enterogenous intoxication are frequently improved by the internal use of hydrochloric acid. Among the conditions that may be thus treated are **acne**, **impetigo**, **furunculosis**, **erythema nodosum**, and **urticaria**. In the last-named condition the acid has also been used

topically; likewise in disorders associated with profuse sweating and torpid skin. A tub-bath containing $\frac{1}{2}$ to 1 ounce (15 to 30 c.c.) of the acid to every gallon of water may be administered in these cases.

Hydrochloric acid is seldom used as a caustic, but may be so employed in **mercurial stomatitis** with sloughing gums, if no better agent is available. Bayliss has obtained satisfactory results in **sciatica** by applications of the acid, undiluted, to the tender spots occurring on the thigh and calf of the leg in this affection. The applications are repeated on successive or alternate nights according to the condition of the skin. They cause no pain or vesication. After each application the limb is enveloped in cotton and loosely bandaged. The same procedure was employed with benefit in patients suffering from intractable pain in the heels and plantar regions as a sequel to **acute rheumatism**.

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HYDROCYANIC ACID. — Hydrocyanic acid (prussic acid; cyanhydric acid; hydrogen cyanide; formonitrile), when pure, is a volatile, exceedingly toxic liquid, chemically HCN. It is found in nature in the secretion of certain myriapods and potentially in a few glucosids, such as amygdalin, from which it may be set free by ferments, such as emulsin, and by dilute acids. In the kernels of various common fruits, in the leaves of the cherry-laurel, and especially in the bitter almond, both amygdalin and emulsin occur, and contact with water is sufficient to cause the libera-

tion of a certain amount of the poisonous acid. Hydrocyanic acid is official in a 2 per cent. solution, which is a colorless liquid having the odor and taste of bitter almonds. Dilute hydrocyanic acid is prone rapidly to decompose,—into ammonia, formic acid, oxalic acid, and a brown substance,—becoming more or less discolored, and unfit for medicinal use. It should be kept in small, dark-colored, cork-stoppered vials. Among the salts of hydrocyanic, potassium cyanide is official.

PREPARATIONS AND DOSE.—

Acidum hydrocyanicum dilutum, U. S. P. (diluted hydrocyanic acid), containing not less than 2 per cent. by weight of the pure acid. Where possible, it had best be made extemporaneously, mixing 15.54 parts by volume of diluted hydrochloric acid with 44.1 parts of distilled water, adding 6 parts by weight of silver cyanide, shaking, and pouring off the clear liquid after subsidence of the precipitate. Dose, official, $1\frac{1}{2}$ minims (0.1 c.c.); maximal, 6 to 10 minims (0.4 to 0.6 c.c.).

Of compounds related to or containing hydrocyanic acid, the following are, or were, official:—

Sodii cyanidum, U. S. P. (sodium cyanide) [NaCN], a white, amorphous or granular powder, deliquescent and exhaling the odor of hydrocyanic acid. It is freely soluble in cold water.

Potassii cyanidum, U. S. P. VIII (potassium cyanide) [KCN], occurring in white pieces or a granular powder, deliquescent and giving off an odor of bitter almonds in the air, but odorless when dry. It is soluble in 2 parts of cold water, decomposed by boiling water, and slightly soluble in alcohol; solutions of it in water are strongly

alkaline to litmus. Dose, $\frac{1}{8}$ grain (0.12 Gm.).

Oleum amygdalæ amaræ, U. S. P. (oil of bitter almond), a volatile oil yielding not less than 85 per cent. of benzaldehyde and not less than 2 per cent. nor more than 4 per cent. of hydrocyanic acid; freely soluble in alcohol or ether, in an equal volume of 70 per cent. alcohol, but only in 300 parts of water. Dose, $\frac{1}{2}$ minim (0.03 c.c.).

Aqua amygdalæ amaræ, U. S. P. (bitter-almond water), made by dissolving 1 part by volume of oil of bitter almond in 1000 parts of distilled water and filtering. Dose, 1 fluidram (4 c.c.).

Spiritus amygdalæ amaræ, U. S. P. (spirit of bitter almond), made by dissolving 1 part by volume of the oil in 80 parts of alcohol, and adding enough distilled water to make 100 parts. Dose, 8 minims (0.5 c.c.).

Syrupus amygdalæ, U. S. P. VIII (syrup of almond), consisting of spirit of bitter almond, 1 part by volume; orange-flower water, 10 parts, and syrup, enough to make 100 parts. Dose, 1 fluidram (4 c.c.).

Fluidextractum pruni virginianæ, N. F. (fluidextract of wild cherry), made from the bark of *Prunus serotina*, which contains a bitter, crystalline glucosid, and yields a small proportion of hydrocyanic acid and benzaldehyde when rubbed up with water. Dose, $\frac{1}{2}$ fluidram (2 c.c.).

Infusum pruni virginianæ, N. F. (infusion of wild cherry), each quart (1000 c.c.) of which is made from 10 fluidrams (40 Gm.) of wild-cherry bark, and contains also $1\frac{1}{2}$ fluidounces (50 c.c.) of glycerin. Dose, 2 fluidounces (60 c.c.).

Syrupus pruni virginianæ, U. S. P. (syrup of wild cherry), each quart (1000 c.c.) of which is made from 5 ounces (150 Gm.) of wild-cherry bark, and contains also 22 ounces (700 Gm.) of sugar and 5 fluid-ounces (150 c.c.) of glycerin. Dose, 1 fluidram (4 c.c.).

Aqua laurocerasi, B. P. (cherry-laurel water), made by crushing and distilling fresh cherry-laurel leaves with water, and standardizing the resulting distillate to contain 0.1 per cent. of hydrocyanic acid. Dose, 1 fluidram (4 c.c.).

PHYSIOLOGICAL ACTION.—

Although certain bacteria are but slightly influenced by hydrocyanic acid, the latter may be designated a general protoplasmic poison, for in nearly all animals and plants it produces a retardation of the oxidative and nutritive processes, which soon ends in death if the amount applied be sufficient. Geppert found that in spite of the convulsions brought on by hydrocyanic acid the tissues of mammals poisoned with it showed a diminution of both oxygen consumption and carbon-dioxide liberation—a combination of effects demonstrating that cellular respiration is interfered with, which is further confirmed by the fact that in prussic acid poisoning the venous blood exhibits the same bright-red color as the arterial, the oxyhemoglobin not being relieved of its oxygen by the tissues, as is normally the case. Much evidence has been accumulated in favor of the view that the action of prussic acid on tissue respiration is due to interference with the activity of intracellular ferments, in particular the ferments which promote oxidation, the oxidases. According to some,

chemical reactions in general are inhibited by it.

Sections of organs from animals poisoned with potassium cyanide showed little or no oxidase when the presence of the latter was tested for with a mixture of alphanaphthol and dimethylparaphenylenediamine. Since in other varieties of poisoning, as by chloroform, carbon monoxide, in asphyxia, etc., the oxidase reaction is clearly positive, the negative results in cyanide intoxication may be ascribed to a destruction or inhibition by this poison of the ferments that stimulate oxidation. H. Raubitschek (Wiener klin. Woch., No. 4, 1912).

In addition to its general protoplasmic action, however, hydrocyanic acid exerts very definite actions on various special portions of the body, which, appearing somewhat earlier in cases of poisoning than that on general metabolism, contribute largely in the production of the symptoms witnessed under these conditions:—

Nervous System.—Stimulation of the central nervous system, especially the medulla and lower brain centers, first occurs, convulsions being among the most evident results. This is followed by the opposite effect, paralysis, in which the entire cerebro-spinal system appears to participate. The peripheral nerves are not influenced, though if a solution of hydrocyanic acid be applied externally to the skin, partial anesthesia, with a feeling of numbness, will be produced.

Respiration.—The respiratory centers are included in the effects on the medulla, already mentioned. The breathing at first becomes very unusually rapid and deep, then irregular during the convulsions, and finally very slow,—though still deep,—cessation ultimately resulting from complete paralysis of the centers.

Circulation.—Primary stimulation of the vasoconstrictor and vagal centers in the medulla results in both a rise of the blood-pressure and a slowing of the heart rate. Later, as the stimulation passes into depression, the pressure falls; but the heart rate continues slow, the vagal effect being now replaced by direct depression of the heart by the drug.

Stimulation of the respiration was observed in the rabbit within three seconds after an injection of sodium cyanide into the jugular vein had been started. Stewart having found the average circulation time from the left jugular to the right carotid in the rabbit to be 2.8 seconds, it is obvious that the cyanide acts almost instantaneously on reaching the respiratory center. A rise in the blood-pressure from 85 to 136 mm. Hg, and a fall in the heart rate owing to cardioinhibition, took place in six seconds after the beginning of the injection. H. S. Gasser and A. S. Loevenhart (*Jour. Pharmacol. and Exp. Therap.*, Jan., 1914).

On the blood of the living body, hydrocyanic acid seems to exert no direct effect. In drawn blood, however, it tends to combine with the hemoglobin to form the so-called cyanhemoglobin, to which is ascribed the occasional persistence of a life-like red color in the dependent portions of the body, or the formation of bright-red ecchymotic spots, in subjects that have succumbed to prussic acid poisoning.

Absorption and Elimination. — Hydrocyanic acid, whether inhaled or applied to the mucous membranes or an area of abraded skin, is absorbed with great rapidity. Some absorption even occurs from the intact skin. Gréhan found that instillation of the acid in the eyes of mammals caused

death from respiratory paralysis in from two to three minutes. Inhaled or brought into contact with the buccal mucous membrane in large amounts, it will kill almost instantaneously by simultaneous arrest of the respiration and heart action.

Where the dose of hydrocyanic acid taken is not sufficient to produce death, it appears to undergo prompt alteration in the system. Part of it is changed into sulphocyanides, while the remainder is otherwise altered in some as yet unknown manner. As these changes take place, tissue oxidation is released from the restraining influence of the acid, and the venous blood tends to resume its normal bluish aspect.

Excretion of the sulphocyanides formed from the acid takes place rapidly (one-half to one hour) by way of the kidneys. A certain proportion of the volatile acid itself appears also to pass out by way of the lungs.

UNTOWARD EFFECTS AND POISONING.—In slightly excessive doses hydrocyanic acid may cause temporary nausea, faintness, giddiness, feeble heart action, and motor weakness.

In large toxic amounts it is one of the most rapidly acting of all poisons. While in most instances of poisoning in human beings a ten-minute interval precedes death, a fatal ending has been known to occur within two minutes, and consciousness may be lost within a few seconds after the drug has been taken. Where the victim survives one-half to one hour recovery is likely to follow, though exceptions to this rule have been recorded.

When the poison is taken into the mouth, a burning, bitter taste, fol-

lowed by salivation and a sensation of burning in the mouth and throat, is first experienced. Giddiness, headache, mental confusion, and nausea appear immediately after, and are followed, in turn, by slow heart action, dyspnea, and extreme motor weakness. The victim commonly drops to the floor a few moments after the taking of the poison, and unconsciousness early supervenes. Violent convulsions frequently follow, soon giving way to complete motor paralysis, the respiration becoming greatly impaired and finally ceasing, while cardiac beats continue for some time after. During the convulsive stage, there may be vomiting and a discharge of urine and feces. The pupils are dilated, the eyeballs protrude, the jaws are clenched together, and froth, sometimes bloody, escapes from the mouth. Circulatory enfeeblement and a clammy skin are marked features. The odor of bitter almonds is a characteristic accompaniment, and may also be observed later, upon opening the body at the autopsy; it tends, however, rapidly to disappear.

Case of prussic acid poisoning. The woman almost instantly fell to the floor, became unconscious, and had severe tetanic convulsions. Her face became dusky, and she died in about twelve minutes. Autopsy one hour after death: Face slightly cyanosed: lips, mouth, and tongue slightly eroded; pupils widely dilated; mouth and nostrils frothy. Mucous membrane of stomach and upper part small intestine bright red in color, swollen, and intensely injected. Moderate engorgement of the brain, liver, kidneys, and spleen. The lungs were much engorged and edematous, and there were numerous subpleural ecchymoses. The blood was everywhere fluid, of a cherry-red color, and gave off a marked odor of

prussic acid. Baker (Boston Med. and Surg. Jour., No. 19, 1899).

Case of a student who let fall a reagent glass containing some hydrocyanic acid. In stooping to pick it up he inhaled the fumes for a moment. Vertigo, motor unrest, headache, small, filiform pulse (128), and enlargement of the right heart, with cyanosis, were noted. The urine showed numerous casts and considerable albumin, and the temperature was 38.3° C. (100.4° F.). These symptoms persisted for a week, the albuminuria till the ninth day. (Deut. med. Woch., Bd. xxxii, No. 42, 1906.)

Case of a man who was cleaning silver with a solution of potassium cyanide in a hotel, and noticed itching and brown discoloration of the hands and forearms, blackening of the nails, and dizziness whenever he placed his hand close to his mouth. He finally developed a severe mucous diarrhea, became somewhat delirious for a few days, and experienced pain in the lower limbs, the ankles becoming stiff. Motor power in both legs and arms was then partly lost, and catheterization became necessary. Two months later he was still in bed, with complete loss of power in the lower limbs and almost complete in the upper. There was pronounced muscular atrophy. Only after six months did improvement set in, the muscles slowly increasing in bulk and function returning. Collins and Maitland (Jour. of Nerv. and Ment. Dis., July, 1908).

Though acting with extreme rapidity, hydrocyanic acid is not, from the standpoint of quantity, as toxic as certain alkaloids, *e.g.*, nicotine and aconitine. The lethal dose of the pure acid in man is considered to be about 1 to $1\frac{1}{2}$ minims (0.05 to 0.08 Gm.). Garstang reported a case of death in an adult after ingestion of 30 minims of the official diluted acid.

Cyanides, *e.g.*, potassium cyanide,

produce the same effects as the free acid, but somewhat larger amounts are required to produce such an effect. Thus, the lethal dose of potassium cyanide is 3 to 5 grains (0.2 to 0.3 Gm.). Commercial potassium cyanide sometimes contains less than 50 per cent. of the pure compound. In some instances the poisonous action of potassium cyanide is exerted more slowly than is usually the case with the free acid.

Potassium cyanide acts as an alkaline escharotic, and lesions due to this action may be observed *post mortem*, viz., swollen and brownish areas on the mucous membranes. The blood will usually be found fluid, but its color is not constant (Sollmann); it may be either very dark or bright red.

Treatment.—The stomach should be at once washed out. Where no facilities are at hand, the simplest and least time-consuming procedure will be to give mustard and water and tickle the throat. If there is time, the administration of, say, 20 grains (1.3 Gm.) of potassium carbonate dissolved in an ounce (30 c.c.) of water, followed by a mixture of 10 grains (0.65 Gm.) of ferrous sulphate and $\frac{1}{2}$ dram (2 Gm.) of magnesium oxide in the same quantity of water, is likely to be of considerable utility, the cyanide group being thereby altered to the much less toxic ferrocyanide. The ingestion of a solution of cobalt nitrate and the subcutaneous injection of sodium thiosulphate (hypo-sulphite) are other measures that have been advised. Where hydrogen dioxide solution is immediately available, its addition to the water employed in washing out the stomach has been advised, on the ground that it will oxidize the poison to the rela-

tively harmless oxamide. The experiments of Martin and O'Brien, however, seem to have demonstrated the futility of this measure, the interaction of hydrocyanic acid and hydrogen dioxide *in vitro* requiring from twenty to seventy minutes. In poisoning by potassium cyanide the ingestion of vinegar has been suggested—merely for the purpose of preventing the alkaline caustic action of this salt.

Experiments showing that hydrogen dioxide is practically worthless in cyanide poisoning. Cobalt salts are valuable, but produce gastro-enteritis. Ferrous salts administered with sufficient alkali are as efficacious as cobalt salts. At the body temperature the formation of ferrocyanides is instantaneous. In all mines where cyanide processes are employed there should be kept solutions of ferrous sulphate, weak potash, and a small packet of magnesium oxide, together with a stomach-tube and a suitable receptacle for mixing, so that the remedies can be administered without delay. The authors recommend 1 ounce (30 c.c.) of a 23 per cent. solution of ferrous sulphate; 1 ounce of a 5 per cent. solution of caustic potash; 30 grains (2 Gm.) of powdered magnesium oxide, together with a metal receptacle of 1 pint capacity and a stomach-tube. The first two solutions should be kept in air-tight tubes which can be broken into the receptacle. The powdered magnesia and $\frac{1}{2}$ pint (250 c.c.) of water are then added, and the mixture shaken up and administered. This amount of antidote will counteract 75 grains (5 Gm.) of potassium cyanide. C. J. Martin and R. A. O'Brien (*Intercol. Med. Jour. of Austral.*, vol. vi, p. 245, 1901).

Potassium-cyanide poisoning is not infrequent among workmen occupied in the process of gold reduction, occurring oftenest where the hands and arms are necessarily immersed

in the cyanide-containing solution. Susceptibility varies in different individuals. Poisoning occurs most easily when the solution is very cold. The local symptoms are itching, scarlet specks on the skin merging to form patches, and papular elevations. Giddiness and headache may be experienced. In such cases the author advises that the hands and arms be placed in a very dilute solution of hot **sulphuric acid** for several minutes every hour. The cyanide is acted upon by the sulphuric acid, with resulting liberation of free hydrocyanic acid, which evaporates and is absorbed and eliminated rapidly. The redness of the skin soon fades. J. W. Nolan (Jour. Amer. Med. Assoc., Feb. 1, 1908).

One of the most useful measures in cyanide poisoning appears to be that suggested by Jona, consisting in the immediate free administration of a dilute solution of **epinephrin**, which, by delaying the absorption of the poison (potassium cyanide) through constriction of the vessels in the gastric mucosa, will give time for effectual removal of the gastric contents by mechanical means or neutralization of the poison *in situ* with some chemical antidote.

When 4 to 5 c.c. (1 to 1¼ drams) of a 1:10,000 solution of epinephrin per kilogram of body weight are introduced into a rabbit's stomach within five minutes after the administration of a lethal dose of potassium cyanide (0.01 Gm. per kilo—⅓ grain per 3½ pounds) and Martin and O'Brien's antidote given, or the stomach washed out within four or five minutes after the administration of epinephrin, the animal's life is saved. In man the amount of epinephrin used should be about 90 c.c. (3 ounces) of the 1:10,000 solution, followed later by about 50 c.c. (1½ ounces). The following procedure is advised in cyanide poisoning: 1. **Epinephrin**

to be immediately given. 2. **Martin and O'Brien's antidote**, if at hand. 3. **Wash stomach out**. 4. Give more epinephrin. The object of the second dose is to retard the absorption of any of the poison which escapes the washing-out process or antidote. It might also be advisable to give a brisk **saline purge** soon afterward. When the Martin-O'Brien antidote is not at hand, the order of procedure should be: 1. Epinephrin. 2. Washing stomach out. 3. More epinephrin. Jona (Brit. Med. Jour., Feb. 8, 1913).

According to Sollmann, brisk **artificial respiration**, begun immediately, is of assistance in promoting elimination of hydrocyanic acid—where the free acid has been taken—by way of the lungs. In any case stimulant measures will soon be indicated, including **alternate hot and cold affusions** to the face and the chest or back, inhalation or ingestion of **ammonia**, and injections of **ether**, **atropine**, **strychnine**, **caffeine**, or **brandy**. Heat should be applied **externally** in the exceptional, protracted cases.

THERAPEUTICS.—Hydrocyanic acid is no longer as extensively employed as formerly in the treatment of disease, the effects obtained from it being procurable as well or better with other less actively toxic agents.

In various forms of **nervous vomiting**, the **vomiting of pregnancy** or that of **hepatic cirrhosis**, the reflex vomiting of **pulmonary tuberculosis**, and that which accompanies some brain diseases, Bartholow suggested the use of a mixture consisting of 1 dram (4 c.c.) of the official dilute acid and 2 ounces (60 c.c.) of cherry-laurel water; of this the dosage advised was one teaspoonful every two to four hours.

In gastric hypersensitiveness or

pain, especially that of nervous origin, —**gastralgia**,—the dilute acid has been often prescribed as a local analgesic, although, according to W. E. Dixon, the amount generally given is insufficient to produce the effect with which the drug is credited. In **enteralgia** the acid has also been used.

In **cough** arising from irritation in the pharynx or bronchial tubes, and of nervous, persistent character, dilute hydrocyanic acid, given in the dose of 2 or 3 drops in a teaspoonful of syrup of wild cherry, is credited with affording prompt relief. If a continuous effect is required, however, the dose will have to be repeated at ten- or fifteen- minute intervals. Contrary to what one might expect, such repeated administration does not entail danger of poisonous effects, the same rapidity of elimination which necessitates frequent administration of the agent obviating the likelihood of a summated action. A few observers deny the acid all value in cough.

As flavoring agents, the oil of bitter almonds and its preparations, and especially the preparations of wild cherry, as well as cherry-laurel water, are frequently availed of.

Externally, prussic acid is undoubtedly capable of giving relief in **pruritus** and other affections accompanied with itching. In **pruritus**, **lichen**, and the **syphilodermata** Fox has suggested the use of the following:—

℞ *Hydrargyri chloridi*
corrosivi gr. j (0.06 Gm.).
Acidi hydrocyanici
diluti f3j (4 c.c.).
Emulsi amygdalæ .. f3vj (180 c.c.).

M. Sig.: Apply externally.

A lotion of ½ to 1 dram (2 to 4 c.c.) of the dilute acid in 1 ounce (30 c.c.)

of rose water might also be used. Care should be taken not to apply such a preparation to broken skin surfaces.

Hydrocyanic acid is now rather extensively employed as a destroyer of insects in dwellings, warehouses, and flour mills, as well as on trees and other plant material.

Hydrocyanic acid is, under proper precautions, an excellent remedy for household insects. It is much more effective against all household insects, except beetles, than carbon disulphide. Rats and mice are also killed. The formula per hundred cubic feet of space is: Potassium cyanide, high grade (98 per cent.), 1 avd. ounce (28 Gm.); commercial sulphuric acid, 1 fluidounce (30 c.c.); water, 3 fluidounces (90 c.c.).

Before performing the operation the house must be vacated and all liquid or moist foods removed. All windows are closed and calked, if of loose construction, with wet paper, cotton batting, or gummed paper. A stoneware or crockery jar with a capacity of 4 gallons should be placed in each room, with the exception of large rooms requiring a charge of more than 3 pounds of cyanide, when the charge may be divided.

After placing the water in the generators, the acid is then slowly poured in. The cyanide, in a thin-paper bag, is finally, when all the receptacles have been gotten ready, dropped into the combined acid and water mixture.

The poisonous hydrocyanic acid gas will not be given off to any extent for a few seconds or a quarter of a minute, and there is therefore time to leave the room quickly without danger of breathing it. The gas being lighter than air, the operation of dropping the bags of cyanide into the diluted acid must be begun at the top of the house. The house should then remain closed for twenty-four hours. The doors are then

opened and the windows lowered from the outside. After an hour's airing the house may be entered if no strong odor of gas is detected. The house should not be reinhabited until all traces of the peach-kernel odor have disappeared. L. O. Howard and C. H. Popenoe (U. S. Dept. of Agric., Bureau of Entomology, Circular No. 163, 1912).

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HYDROGEN DIOXIDE.—Hydrogen dioxide (hydrogen peroxide; oxygenated water), in a pure, undiluted state, is an odorless, colorless, syrupy liquid having the composition H_2O_2 . It is unstable chemically, readily decomposing into oxygen and water, and is rarely met with in its pure state. A 30 per cent. solution (by weight) in water can, however, be readily procured. For medicinal and surgical uses a 3 per cent. solution is official. In spite of this relatively great dilution, the solution deteriorates upon exposure to heat, sunlight, or prolonged shaking. It has become almost everywhere the custom to add a small amount of acetanilide to hydrogen dioxide solutions for the purpose of obviating this decomposition, and A. M. Clover has shown by experiment (1913) that this is an extremely efficient procedure, a pure dioxide solution to which 1:2000 of acetanilide had been added deteriorating only 2.7 per cent. in five months, while the same solution, without acetanilide, lost one-half of its strength in three weeks. Acids, especially phosphoric acid, also act as preservatives, but are much less efficient than acetanilide. Pressure exerts no restraining influence on the

decomposition, and the degree of deterioration can be roughly estimated by observing the pressure on the stopper in opening a tightly sealed bottle.

In no case should hydrogen dioxide be stocked for longer than six months by the retailer. While 3 of 5 samples examined were standard, or practically so, as regards strength, in these same 3 the decomposition of the acetanilide used for preservation had progressed to such a point that the color, odor, and taste were extremely marked and the preparations unfit for use. Pure peroxide that is reasonably stable is much to be preferred to one that has undergone partial acetanilide oxidation. (Quarterly Bull. State Board of Health of N. H., July, 1912.)

PREPARATION AND DOSE.—

Liquor hydrogenii dioxidi, U. S. P. (solution of hydrogen dioxide), which contains, when fresh, about 3 per cent. (by weight) of absolute hydrogen dioxide, corresponding to about 10 volumes of available oxygen. It occurs as a colorless, odorless liquid, with a slightly acidulous taste, owing to the presence of a small amount of acid added as preservative. When slowly heated on the water-bath to a temperature not exceeding 60° C. (140° F.) the solution loses water, chiefly; but if rapidly heated, it often suddenly decomposes. Deterioration on keeping is said to be retarded by replacing the stopper in the bottle with cotton. Dose, $\frac{1}{2}$ to 2 fluidrams (2 to 8 c.c.).

Unofficial preparations which contain or act in a manner similar to hydrogen dioxide are as follows:—

Perhydrol, a 30 per cent. (*i.e.*, 10 times stronger than the official) solution of hydrogen dioxide, free from acid. The preparation is itself stable,

but deteriorates rapidly when diluted with water. Not used internally in pure form.

Perhydrol is a clear neutral fluid which disengages 100 times its volume of oxygen when decomposed. Despite the fact that it is free from even traces of acid, it will keep for more than one year. J. Klein (*Rev. trimestr. suisse d'odont.*, vol. xiv, No. 4, 1904).

Magnesium peroxide, a mixture containing not less than 15 per cent. of magnesium dioxide (MgO_2), together with magnesium oxide. It occurs as a white powder, nearly insoluble in water, but gradually decomposing in its presence into hydrogen dioxide and magnesium hydroxide, these compounds reacting, in turn, with liberation of oxygen. Magnesium dioxide is decomposed by dilute acids, a solution of hydrogen dioxide being formed. The product is of value as a gastric and intestinal antiseptic, and has also been used in anemias, rheumatism, and gout. Dose, 4 to 8 grains (0.25 to 0.5 Gm.).

Zinc peroxide, a mixture containing not less than 45 per cent. of zinc dioxide (ZnO_2), together with zinc oxide. It occurs as a yellowish, bulky, tasteless powder, nearly insoluble in water, but gradually decomposing in its presence, with liberation of a maximum of 8 per cent. (by weight) of oxygen. In its dry form it is sterilizable by heat without decomposition. Used externally as dusting powder, with or without admixture of tannic acid, or in a 10 per cent. ointment.

Calcium peroxide, analogous to the preceding, yielding 13.4 per cent. (by weight) of oxygen. Dose, 1 to 5 grains (0.06 to 0.3 Gm.) in water or with sodium bicarbonate.

Strontium peroxide, analogous to the preceding, yielding 11.3 per cent. of oxygen. Used externally as powder or in an ointment.

Sodium peroxide, containing at least 90 per cent. of pure sodium dioxide (Na_2O_2). It occurs as a white or yellowish powder, which dissolves in water to form hydrogen dioxide, from which oxygen is liberated by the heat of the reaction. It is a powerful oxidizing agent, igniting ether on contact, and its solution being strongly alkaline, owing to the production of sodium hydroxide, it is employed only externally in acne, in the form of a paste with liquid paraffin or, to remove comedones, as a soap.

Sodium perborate [$NaBO_3 \cdot 4H_2O$], containing 9 per cent. (by weight) of available oxygen. It occurs in white, soluble granules, decomposed by water into hydrogen dioxide and sodium metaborate, and yielding oxygen when heated to 60° C., or brought into contact with animal tissues or catalyzers. Used as antiseptic and deodorant in suppurative lesions, ulcers, wounds, etc., either applied as a dusting powder or in 2 per cent. solution. It differs from the official hydrogen dioxide in furnishing an alkaline instead of an acid solution.

PHYSIOLOGICAL ACTION.—

Taken into the mouth, the official solution foams and produces a slight pungent, stinging sensation. Its properties are those of a deodorant, germicide, and hemostatic. Its effects are produced by the liberation of oxygen and by consequent oxidation. It destroys rubber, cork, catgut, etc.; and when brought into contact with pus or blood, liberates oxygen

very actively, producing an effervescence.

The "explosive" manner in which it sometimes acts may even distend and rupture tissue and carry infection into the cellular tissues for a considerable distance. Spencer has reported a case of mammary carcinoma in which injection of a small sinus with it resulted in opening up and introduction of infection into the axilla. Taken internally, hydrogen dioxide is not actually poisonous; but it may prove irritating, especially in the bowel.

Hydrogen dioxide kills infusoria and probably other isolated cellular elements, but living tissues do not suffer through any chemical influence it possesses. A 3 per cent. solution of it is the equivalent of a 1:1000 corrosive sublimate solution acting on bacteria suspended in aqueous solutions, but hydrogen dioxide is superior to sublimate in media rich in albuminous fluid and poor in cells. In so far as conclusions can be drawn from test-tube reactions, the antiseptic action of the dioxide can be developed in urine and drinking-water, provided decided quantities of albumin are not present; on the other hand, in conditions met with in wounds where catalytic tendencies are marked no more effect will attend its application than the use of sublimate or aluminum acetate. The foaming caused by the dioxide effects a cleansing of wound surfaces without any injurious action, whence its superiority over acetate of aluminum or sublimate solutions. As a deodorizer it acts instantaneously and powerfully. Honsell (Beiträge klin. Chir., Bd. xxvii, H. 1, 1901).

Colloidal silver hastens the decomposition of hydrogen dioxide without being altered itself. This combined action is extraordinarily effective in cleansing and disinfecting. A putrid endometritis rinsed with even a weak concentration of the two agents loses

its fetid odor immediately. The colloidal silver acts as a catalyzer. The author injects the two substances independently, through separate catheters, in such a way that they blend as they emerge. Potassium permanganate and hydrogen dioxide also enhance each other's action. The most practical form in which to apply the combination is to make two solutions, (1) by adding 35 c.c. (1½ ounces) of 3 per cent. hydrogen dioxide to a liter (quart) of water; (2) by adding 2 Gm. (30 grains) of potassium permanganate and 5 c.c. (1¼ drams) of diluted (30 per cent.) acetic acid to 1 liter (quart) of water. Decomposition commences as soon as the two solutions come together. One Gm. of the pure H_2O_2 yields about 700 c.c. of oxygen. When the two solutions are blending properly the escaping fluid is colorless; if one of the solutions preponderates, it is colored. Therefore, the receptacles with the two solutions must be at the same height and each be connected with a catheter providing for two currents. An ordinary two-way catheter, such as is used for rinsing the bladder, is convenient in treating inoperable uterine cancer. Fűth (Centralbl. f. Gynäk., Bd. xxx, Nu. 35, 1906).

Ptyalin is markedly affected by hydrogen dioxide. A 0.02 per cent. solution inhibits its action slightly, while 0.1 per cent. and stronger solutions practically destroy it. Pepsin and trypsin are relatively immune to its action, not being destroyed by 0.5 per cent. solutions. Rennin, however, is very sensitive, being completely destroyed by a 0.5 per cent. solution and measurably inhibited by a dilution of 1:3000. L. E. Walbum (Berl. klin. Woch., Bd. xlviii, S. 1929, 1911).

Hydrogen dioxide has considerable value in reducing the number of bacteria and the harmfulness of the decomposition products. It cannot, however, be depended on for complete destruction of even such sensitive bacteria as *Bacillus typhosus*, *B. coli*, or *B. prodigiosus* in milk or

water. Commercial preparations of hydrogen dioxide often vary in composition and are not, therefore, to be depended on unless the composition at the time of use is known. Magnesium dioxide tablets, though probably more stable than solutions of hydrogen dioxide, are not soluble and must be pulverized before addition to the substance to be treated, and even then the evolution of hydrogen dioxide seems to be gradual and irregular. Ordinary room temperature is favorable, but a higher temperature is to be preferred, and milk and water should be colored after the period of action to make them palatable and prevent multiplication of the remaining bacteria. For rendering milk and water safe, hydrogen dioxide solutions can at best be considered only an emergency measure. P. G. Heinemann (Jour. Amer. Med. Assoc., May 24, 1913).

Injected subcutaneously in large amounts in herbivorous animals, hydrogen dioxide causes death by general gas embolism; this does not occur, however, in carnivorous animals. Injected intravenously, it causes methemoglobinemia and hemoglobinuria, and tends to destroy the red cells (Colasanti and Brugnola).

THERAPEUTICS.—Hydrogen is an active destroyer of false membranes, pus, and pathogenic germs. It is sometimes used as a diagnostic means for the detection of pus, since contact with the latter causes a foaming and frothing until all traces of pus have disappeared. It is also used in dressing wounds, in which it forestalls suppuration and promotes healing.

In the "parenchymatous" form of **hemorrhage** the 10-volume solution of hydrogen dioxide applied with swabs will dry up the bleeding surface with great rapidity. It acts by causing a rapid formation of fibrin in the mouths of the severed vascular

channels. It is easier to handle than hot water, and is free from the risk of burning the parts. It is especially relied upon in **bone operations** such as the radical mastoid, and is also of the greatest service in the surgery of the nose. In **epistaxis** hydrogen dioxide applied to the bleeding area on a tampon will suffice in most cases to bring the hemorrhage to a standstill. In **uterine hemorrhage** hydrogen dioxide solution, injected into the uterus, or applied on strips of gauze, will arrest bleeding.

As a diagnostic agent, revealing the presence of pus, hydrogen dioxide is of great value. If the antrum of Highmore, *e.g.*, is suspected to contain pus, puncture of its nasal wall with a fine trocar and cannula, followed by injection of some of the solution, will soon settle the point, for if pus is present foaming liquid will at once pour from the nose, bearing on its surface characteristic yellow streaks. In suspected **corneal ulcer** hydrogen dioxide is said to be as valuable as fluorescent, effervescence taking place at the spot where the surface is abraded. D. M'Kenzie (The Hospital; The Antiseptic, June, 1908).

In **purulent affections** the application of hydrogen dioxide to the pus-secreting surfaces and cavities is followed by the most satisfactory effects. Unhealthy suppurating surfaces, **bed-sores**, **gangrenous wounds**, necrotic areas, **cancerous** and **syphilitic ulcers**, etc., are all amenable to its beneficial action. Diluted with 4 to 8 parts of water, it may be used as an injection for **gonococcal urethritis** and **leucorrhea**. Suppuration in **infected wounds** is checked and healing promoted by spraying the parts with hydrogen dioxide before applying the dressings. A 1 per cent. solution is frequently used for irrigating and packing such wounds.

Hydrogen dioxide used in cases of **lupus vulgaris**. It was applied daily to the ulcers in the form of a fine spray. The granulations soon assumed a healthy appearance and cicatrization was rapid as well as permanent. Exuberant granulations may be scraped off before treatment with the dioxide. The remedy is also efficient in chronic or **tuberculous abscesses**, after their contents have been evacuated. C. H. Gunson (Brit. Med. Jour., No. 2147, 1902).

The author has used a 30 per cent. hydrogen-dioxide solution in numerous cases of **ulcers** (especially ulcers of the leg) in **mercurial** and **aphthous stomatitis**. He does not recommend it in chancroids or gonococcal urethritis. In **gonococcal endometritis**, on the other hand, he obtained excellent results in about 50 cases of the chronic and subacute type. The best results were obtained with a 15 per cent. solution. After introducing a tubular speculum into which the cervix fit snugly, 15 to 30 minims (1 to 2 c.c.) of the solution were poured into the speculum, and a cotton probe dipped in the solution introduced into the cervix or uterus. Hemorrhage destroys the action of the peroxide. The concentrated solution of hydrogen dioxide has no hemostatic properties; to stop bleeding one must use a 2 to 5 per cent. solution. The author effected cures with 10 to 12 applications repeated every fifth day, the entire duration of treatment being about two months. Paul Richter (Therap. Monats., Nu. 5, 1904).

In **psoriasis** perhydrol rapidly removes the scales and prepares the way for further treatment. Excellent results were obtained in **favus** with compresses dipped in a 5 per cent. solution and changed every two hours. Twenty-four hours later all yellow crusts, and with them the diseased hairs, were removed and a clean, reddened scalp was exposed. The reddening soon subsided, and three weeks after cessation of treatment there had been no relapse. A

pigmented nevus was rapidly removed by painting it with perhydrol. In chancroids, as long as there is a tendency to the spread of ulceration, it appears to be useless, but when the process is at a standstill it rapidly cleans the surface and hastens healing. In **ulcerated cutaneous gummata** the solution, sponged on the surface, acts similarly. In **noma** of the genitals sponging the surface twice daily with the solution and the application of pieces of gauze soaked in a 5 per cent. solution and changed every two hours gave brilliant results. Equally good effects were obtained in **mercurial stomatitis** by painting the ulcerated gums once daily with the concentrated solution, and gargling frequently with a 3 per cent. solution. M. Oppenheim (Wien. med. Woch., Jan. 30, 1904).

In **vulvovaginitis** of young girls a 10 per cent. dilution of perhydrol may be injected into the vagina with a glass syringe. Irrigations are too expensive, but ordinary gauze may be saturated with the solution and introduced through a speculum. **Decubital ulcers** heal rapidly, and **ulcerating carcinomata** lose their offensive discharge and soon present a clean surface. The indications for using perhydrol are, briefly: (1) In all suppurating and ulcerative processes of the vagina and vulva; (2) in all gangrenous processes of the vagina and cervix; (3) in simple **erosion** and marked **leucorrhœa**; (4) in severe inflammations of the endometrium, especially after abortions. Walther (Med. Klinik, No. 3, 1905).

In using perhydrol in surgical cases, glycerin is to be preferred to water as solvent, since the evolution of oxygen goes on more slowly and the action is thus prolonged. In **chancroids** the ulcer should be washed with 3 per cent. boric acid solution, next cauterized with copper sulphate, and tampons saturated with 3 per cent. perhydrol-glycerin then applied and renewed three times a day. Good results were also obtained in **ulcers** about the **nails**,

abscesses, osteitis, and periostitis. C. Giglio (*Gaz. degli Osped. e delle Clin.*, No. 124, 1905).

Perhydrol in a dilution of 1:9 recommended in **abscesses** of the **antrum of Highmore**, and **wounds** and **ulcers** of the **mouth** in general. Some use it in place of absolute alcohol to irrigate **carious cavities**, others in **pyorrhea alveolaris**. E. Friedlander (*Aerzt. Vierteljahres-Rundsch.*, Nu. 3, 1908).

Hydrogen dioxide is a most efficient uterine and vaginal antiseptic. It does not cause local irritation and works its way well into the mucous folds, and fears of gas embolism are groundless. The author first had recourse to it in a case of **puerperal infection** in which the usual remedies had failed to give relief. With a double-current cannula, he injected about 1 ounce (30 c.c.) of a $3\frac{1}{2}$ per cent. solution of hydrogen dioxide into the uterine cavity. This was repeated every twenty-four hours for six consecutive days. The injections were painless and effected a rapid amelioration of the local and general symptoms, the patient becoming apyretic and convalescent at the end of six days. Prompt results were also obtained in the case of a woman 32 years of age who after an abortion at six months presented a **subacute endometritis** with hemorrhage. After curetting the uterus, the author injected about 1 ounce (30 c.c.) of hydrogen dioxide. The resulting foamy scum swept out of the uterus blood-clots and particles of mucus and mucous membrane. The hemorrhage ceased promptly, so that the author was able to operate without tampons. F. Grandoni (*Semaine méd.*, Sept 27, 1911).

Hydrogen dioxide may be successfully used in **abscess of the brain**. In old **sinuses** its employment should be followed with balsam of Peru, which encourages granulation (Morris); or, one may alternate its use with injections of a mixture of

equal parts of ether and balsam of Peru—a procedure of great value in all suppurating cavities with indurated edges (Graff). Where the dioxide is injected into cavities one must see that there is free exit for the gas liberated from it.

According to Pane, hydrogen dioxide acts more strongly against **anthrax** bacilli than mercury bichloride, impeding their growth and after some days killing the spores when mixed with the fluid culture medium in the ratio of only 1 to 352.

In **acute otitis media** the procedure followed by Politzer consists in syringing the meatus with warm sterile water, filling the passage with hydrogen-dioxide solution while the patient's head is tilted on the opposite side, and then inflating the ear with the Politzer bulb through the Eustachian tube, air being thus blown through to the meatus and the liquid finding its way into the tympanum. This treatment may be employed soon after the beginning of the discharge. If no diminution of secretion takes place in a few days resort should be had to boric acid. In **chronic otitis media** a rapid diminution of the discharge is, in a certain proportion of instances, observed after several days' use of hydrogen dioxide, and in a few cases its complete disappearance. Especially in the septic, neglected forms of otitis, treatment may be advantageously begun with hydrogen dioxide, and after several days the ordinary antiseptic treatment pursued, the latter acting more rapidly when preceded by the use of the dioxide. In desquamative suppuration of the middle ear, masses of epidermis heaped up in anfractuositities of the

tympanic cavity, inaccessible to ordinary syringing, are often brought to the surface during the rapid liberation of gas following the introduction of hydrogen dioxide (Politzer). After the "foaming" is over, the otitic ear should be carefully dried out, and some suitable astringent or chemically antiseptic solution may then be instilled. Where drainage of the middle ear through the tympanic membrane is not free, caution should be exercised in the use of hydrogen dioxide.

Obstructive masses of cerumen in the ear can be, to some extent, disintegrated by placing a small quantity of hydrogen-dioxide solution in contact with it for a few minutes, after which the plug can be removed by syringing with warm water. The strength of dioxide solution used in the ear is generally 1 or 1½ per cent., *i.e.*, a 1 in 3 or 1 in 2 dilution of the official 3 per cent. solution.

In **subacute and chronic suppuration of the middle ear** hydrogen dioxide is a very useful application, acting as a disinfectant and deodorant, and to some extent also as an astringent, the active effervescence occurring when it comes into contact with blood or pus, exerting a mechanical action which helps in the breaking up of masses of septic material. The author has never observed any signs of irritation from the use of the 10-volume strength when a pure preparation was used.

When discharge from the ear is profuse, one should first wash away the pus with a syringeful of warm lotion or boiled water, and then fill the meatus with hydrogen dioxide (cold), the patient holding the head well over to one side. The effervescence should be allowed to go on till it ceases, or at least for several minutes, a little fresh dioxide being added from time to time. The froth

and débris are then syringed out and the parts dried and dressed as desired. Thus, in cases with considerable destruction of the drumhead and good drainage the meatus may be dried with pledgets of absorbent cotton, and then filled with powdered boric acid; or if granulation tissue be much in evidence, with perhaps a smallish perforation and imperfect drainage, drops containing alcohol (25 to 100 per cent.) may be instilled. Pure cerumen is not much affected by hydrogen dioxide, but plugs of epidermal and mixed nature are generally rapidly softened by it.

In perforating **mastoid operations** the writer has found the dioxide of use in cleansing foul cavities and in checking oozing from small vessels. The treatment with hydrogen dioxide and alcohol drops, as in chronic otorrhea, answers well in combination with packing after the radical operation. Lamb (*Folia Therapeutica*, Oct., 1907).

Other fields for the use of hydrogen dioxide are the oral and nasal cavities. In **ulcerative stomatitis, dental caries, thrush, tonsillitis, etc.**, this agent may be used as a wash or gargle, prepared by adding a tablespoonful of the 3 per cent. solution to a tumblerful of boiled water. In the various forms of **"septic" and membranous sore throat**, however, the best way to apply the remedy is to spray it directly on the inflamed surface. According to some, even **leucoplakia** may be benefited through the use of hydrogen dioxide as a mouth-wash. For **mouth disinfection and deodorization** in febrile and wasting diseases, a 2 or 3 per cent. dioxide solution is decidedly efficient. Walters found 5 to 10 per cent. solutions highly useful in **mercurial stomatitis**. In **diphtheria** hydrogen dioxide has been recommended for the destruction and removal of false membrane. On con-

tact with it an active effervescence ensues, and the membrane comes away in shreds. The dioxide is best applied in spray form, using a rubber or glass-tipped atomizer on account of the oxidizing influence upon metal spray tubes. It may also be applied by means of a swab or a glass syringe. It does not prevent, however, a return of the membrane.

In 6 per cent. strength, hydrogen dioxide forms an excellent disinfectant for the mouth and throat. **Catarrhal** and **ulcerative stomatitis** yield to its use alone. On account of lack of toxicity it can be used in the youngest children, for if swallowed it can do no harm. Similar considerations apply to **aphthous** and **mercurial stomatitis**. In **simple** and **lacunar tonsillitis**, and in tonsillitis accompanying the infectious diseases, gargling with peroxide is very effective. In **laryngeal tuberculosis** the author found it more efficient than lactic acid. The inhalation of the steam from boiling dioxide is useful in laryngeal tuberculosis, as also in **putrid bronchitis**. Edmund Nacht (Aerzt. Cent.-Zeit., Nu. 21-22, 1904).

Good results obtained in local **anesthesia for dental work** with an anesthetic mixture consisting of equal parts of 5-volume hydrogen-dioxide solution and 1 per cent. cocaine or 4 per cent. novocaine solution. The chief advantage of such mixtures is avoidance of the untoward effects of epinephrin, while the bloodless operative field and increased anesthetic power of cocaine or novocaine effected by epinephrin are nevertheless retained.

The injections should be made superficially and slowly, with a tepid solution, and stopped as soon as the tissues become pale. The solutions referred to are especially indicated for the extraction of teeth in nervous individuals, children, old persons, diabetics, and pregnant women. G. Mahé and P. Vanel (Presse méd., April 23, 1913).

In **ozena** hydrogen dioxide will rapidly overcome the odor. Removal of intranasal tampons without hemorrhage can be facilitated by moistening with dioxide solution. Application of the 3 per cent. solution to the nasal mucosa, as well as to the uterine cervix, is useful, to remove adherent mucus and expose the membrane for local medication.

In disease of the nose the uses of peroxide of hydrogen are chiefly for the **disinfection and removal of purulent discharges**, and for the checking of **hemorrhage**. In operations for the **removal of polypi** an application of a few minutes will usually check the bleeding sufficiently. When the head of the middle turbinal is removed the little artery running along the free border of the turbinal is divided and may cause troublesome reactionary hemorrhage after the effect of cocaine and adrenalin has passed off. Such bleeding may be readily controlled by packing a pledget of absorbent cotton soaked in peroxide of hydrogen upward and backward against the cut surface of the turbinate. If a silk thread be attached to the compress it can be removed later by the patient.

In submucous **resection of the septum**, after removal of the packing, hydrogen dioxide may sometimes be applied with advantage to the interior of the nares, either by dropping or spraying. When much reactionary disturbance follows the use of the galvanocautery, hydrogen dioxide is an excellent application. A little cocaine should be sprayed on first, and the wound can then be soaked with dioxide, cleansed, and dressed without pain.

In most cases of **epistaxis** a pledget of cotton with dioxide, introduced just beyond the vestibule and pressed against the septum with the tip of the finger applied outside the ala, will, if the pressure be maintained for ten or fifteen minutes, arrest the bleeding.

Recently the author has frequently employed undiluted perhydrol, dabbing it lightly with a cotton brush on foul and suppurating surfaces. He has seen no signs of injurious irritation following its use. Lamb (*Folia Therapeutica*, Oct., 1907).

Membranous conjunctivitis yields rapidly to hydrogen dioxide. In **marginal blepharitis** Ayers has reported good results from first removing the crusts, instilling cocaine, and rubbing dioxide solution along the edge of the lid with a little cotton wrapped on the end of a toothpick.

In **purulent conjunctivitis**, *e.g.*, **gonococcal** and **membranous**, hydrogen dioxide gives very satisfactory results. In the former case it should be used in the form of a warm douche (40° C. or 104° F.). The dioxide is not decomposed at this temperature, while the gonococci are destroyed. Whereas silver nitrate is contraindicated in **corneal ulcerations**, hydrogen peroxide is of great use. It disinfects the ulcer and, owing to its peculiar action on the toxins generated, iritis and hypopyon are less frequently noticed in cases of pneumococcal infection. In **blepharitis** hydrogen dioxide can be recommended for removing the crusts. In the **pannus** associated with **trachoma** or chronic corneal conditions, after the operation of syndectomy has been performed, a probe tipped with cotton-wool and saturated with the drug should be rubbed into the gap from which the conjunctiva has been removed. This measure, followed by the instillation of dionin and the injection, subconjunctivally, of salt solution, has brought about removal of many dense nebulæ.

Lachrymal obstruction and **purulent dacryocystitis** are greatly benefited by hydrogen dioxide; an obstruction that resists everything else will give way before it. Stretching of the sac wall during the syringing, sometimes causing puffiness of the

eyelids and the inner canthus for twelve to twenty-four hours, can be avoided by using as little force as possible; when much of the fluid has escaped into the tissues, the edema is extensive and may last several days. This does not apply to its use immediately before the operation of excision of the sac, when it is desirable to remove every trace of pus. P. A. Harry (*Prescriber*, June, 1913).

Freckles can be removed by bringing into contact with them a non-acidified 3 per cent. hydrogen-dioxide solution twice daily, for half an hour, and rubbing in with wool-fat thereafter. Other conditions in which the use of dioxide has been counseled are **frost-bites**, **pigmented nevi**, **ringworm**, and **furunculosis**. Its application tends to counteract pain and prevent secondary poisonous effects in **bites** and **stings of insects**.

A boy was seen with a severe powder burn of the whole face and neck. He was cleaned up thoroughly and several grains of powder removed from each eye, but the face was black with stains and embedded particles of powder. Orders were given to keep the face covered with pieces of lint saturated with glycerin, 1 part, and hydrogen dioxide, 3 parts. In a couple of days all the particles and stains were completely removed without any of the tedious and painful picking process usually resorted to. All marks promptly healed. Clark (*Amer. Med.*, June 1, 1901).

After picking out all the powder he could from the face of a man badly burned by the premature explosion of a shell that he was forcing into a rifle, the author dropped one or two drops of hydrogen dioxide into each opening, and then bathed the whole surface. Although there was only one treatment, not the slightest trace of powder staining followed. Stansbury (*Amer. Med.*, Aug. 17, 1901).

Where gauze adheres so closely to **wounds** that the granulations are torn, causing hemorrhage and pain, the difficulties can be overcome by saturating the gauze with hydrogen dioxide. It must be thoroughly applied. Bubbles of gas form between the tissues and the gauze, liberating the latter. This will be facilitated by slight traction upon the dressing, and, as it is lifted, allowing the dioxide to flow between the dressing and wound. Mikulicz and Poncet (*Le Scalpel*, No. 48, 1901).

Hydrogen dioxide affords a simple and painless means of **removing superfluous hair**. Cotton is wet with the solution, applied to the region to be treated, and left in place for several minutes. This is repeated daily. The hair gets lighter in color, and finally disappears. It will grow again, however, necessitating another course of treatment. Care should be taken not to have the dioxide come into contact with the clothing. P. Gallois (*Nouv. rem.*, vol. xviii, No. 22, 1902).

If hydrogen dioxide be added to milk in the amount of 0.35 pro mille, the milk will keep for many days and the number of germs present decrease to a very low number. It is always best to heat the milk up to 50° C. after the addition of the peroxide, since a certain amount of free oxygen will be formed, which is strongly bactericidal. To avoid dilution of the milk it is best to use perhydrol, which contains 30 per cent. of dioxide. The taste is not altered, and experiments show that the digestibility remains the same. E. Baumann (*Münch. med. Woch.*, June 6, 1905).

Addition of hydrogen dioxide to sputum recommended as an effectual means of breaking up tenacious masses and distributing the tubercle bacilli evenly. Peters (*Münch. med. Woch.*, Bd. liv, Nu. 9, 1907).

Internally, the use of hydrogen-dioxide solution has been advocated in the **vomiting of pregnancy** and in

hyperchlorhydria. In the latter condition it has been found capable of causing a marked, though temporary, diminution of free acid in the stomach content.

A 1 per cent. solution of hydrogen dioxide causes increased secretion of saliva when the mouth is rinsed with it. It reduces the gastric total acidity, and especially the free hydrochloric acid, far surpassing oil in this respect. The free acid can be reduced to zero, but it is a question whether this is due to restriction of the secretion of acid or to increased production of mucus. When the drug is used to reduce the acidity within normal bounds, the author advises giving it like a mineral water, in the morning fasting, in the proportion of 1:3 parts in from 200 to 300 c.c. (6% to 10 ounces) of water. It can also be used in a 0.25 or 0.5 per cent. solution for rinsing the stomach in **hyperacidity** and **acid fermentation**. A. Petri (*Archiv f. Verdauungs-Krankh.*, Oct., 1908).

A patient had the usual symptoms of **hyperchlorhydria** and suffered a great deal at night with intense burning in the epigastrium. A 1:6 dilution of the official hydrogen dioxide quickly relieved the distress, and, although he stated that the "special water" made him sick for the time being, he became accustomed to it and drank no other water during his stay in the hospital. He was discharged cured, no other drug being used except the dioxide. Goodman (*N. Y. Med. Jour.*, Nov. 6, 1909).

In 14 patients with an excess of hydrochloric acid in the gastric content, an ordinary test-meal, consisting of a piece of dry toast and 300 c.c. (10 ounces) tea, was given, extracted at the end of the usual time, and examined. After twenty-four hours a test-meal consisting of a piece of toast and 300 c.c. (10 ounces) of 0.5 per cent. hydrogen dioxide solution was given and examined. In the latter there was a remarkable diminution of the free hydrochloric

acid in comparison to the amount aroused by the ordinary Ewald meal. In some instances there was a total absence of free acid, but in no instance were unpleasant symptoms complained of. Therapeutic use was made of this knowledge with fairly good results. Goodman (Penna. Med. Jour., Feb., 1910).

After giving 15 c.c. ($3\frac{3}{4}$ drams) of hydrogen dioxide in 150 c.c. (5 ounces) of water the acid in the stomach is much diminished, and after 20 c.c. (5 drams) in the same amount of water it disappears altogether. The inhibitory action of peroxide upon free acid production is only of short duration, but if teaspoonful doses are given for some time, in cases of **hyperchlorhydria**, it is possible to keep the amount of free acid well within normal limits. The **gastralgia** is also favorably affected in nearly all cases. Girardi (Gaz. degli osped., p. 145, 1910).

Small quantities of hydrogen dioxide, as 4 to 8 c.c. (1 to 2 drams) of the 3 per cent. solution, before meals, once or twice a day, only slightly lower the acidity in cases of **hyperchlorhydria**. Fifteen c.c. ($3\frac{3}{4}$ drams) have a decided effect, but the patient is nauseated. Giving it in almond water, as suggested by Poly, lessens this trouble. The action of dioxide is only temporary; whereas immediately after its use the free acid and pepsin content are greatly lowered or absent, next morning they are generally normal or nearly so. Much mucus is nearly always found in the stomach content after 300 c.c. (10 ounces) of 0.5 per cent. dioxide solution have been given. In 2 cases in which the treatment was continued for four weeks, it took two days for the content to return to normal after discontinuance of the drug. It is possible that a longer use would do lasting damage. Neilson (Jour. Amer. Med. Assoc., Feb. 7, 1914).

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HYDRONEPHROSIS. See KIDNEYS, DISEASES OF.

HYDROPERICARDIUM. See HEART AND PERICARDIUM, DISEASES OF.

HYDROPHOBIA. See RABIES.

HYDROPNEUMOTHORAX. See PLEURA, DISEASES OF.

HYDROSALPINX. See OVARIES AND TUBES, DISEASES OF.

HYDROTHERAPY. See WATER.

HYDROTHORAX. See PLEURA, DISEASES OF.

HYOSCINE. See SCOPOLA AND SCOPOLAMINE.

HYOSCYAMUS. — *Hyoscyamus* (U. S. P.) consists of the dried leaves and flowering tops of the *Hyoscyamus niger*, or henbane, collected from plants of the second year's growth. It is naturalized in nearly all temperate regions, including the United States. It belongs to the family *Solanaceæ*, of which belladonna, stramonium, and scopolia are also members. The fresh herb has a rank, heavy, unpleasant odor, which disappears on drying. The plant contains three alkaloids, *hyoscyamine*, present in largest amount; *hyoscine* (scopolamine), present in less amount, but more abundantly than in belladonna or stramonium, and *atropine*, present only in traces. The combined percentage of these alkaloids ranges from about 0.03 to 0.25 (most frequently from 0.06 to 0.15 per cent.), of which hyoscyamine constitutes about three-fourths. In addition, *hyoscyamus* contains hyospicrin, a bitter glucosid; an odorous principle; potassium nitrate, and calcium oxalate (Kraemer).

Hyoscyamine is isomeric with, *i.e.*, has the same chemical formula as,

atropine [$C_{17}H_{23}NO_3$], and is distinguished from it merely by its different optical properties. Atropine, when examined in the polariscope, is inactive, because it is a mixture of levohyoscyamine and dextrohyoscyamine, which neutralize each other as regards rotation of the plane of polarized light.

The natural hyoscyamine, on the other hand, which consists of more or less pure levohyoscyamine, rotates the plane of polarized light to the left to a greater or less degree. Levohyoscyamine readily changes to atropine, and a partial transformation of this nature is known to occur during the process of extraction of the alkaloid from the plants containing it.

Hyoscine is chemically identical with scopolamine [$C_{17}H_{21}NO_4$]. No essential distinction is made between the two alkaloids. A relationship between them may be said to exist, however, somewhat similar to that borne by atropine to levohyoscyamine, the term scopolamine being properly applied—through a tacit understanding—to that form of the alkaloid which will rotate the plane of polarized light to the left to the maximum degree of which the molecule under consideration is capable, while the term hyoscine is less precise, being applicable to specimens of the alkaloid ranging from completely levorotatory (in which case the term scopolamine would also be applicable) to optically inactive.

PREPARATIONS AND DOSE.—

Hyoscyamus, U. S. P. (hyoscyamus), the dried drug, required to yield, when assayed according to the official process, not less than 0.065 per cent. of the alkaloids of hyoscyamus. Dose, 4 grains (0.25 Gm.).

Fluidextractum hyoscyami, U. S. P. (fluidextract of hyoscyamus), made by moistening powdered hyoscyamus with alcohol diluted with water (2:1), percolating, evaporating a certain portion of the product, and mixing it with the remainder; the finished product is required to contain 0.055 to 0.075 per cent. of alkaloids. Dose, 3 minims (0.2 c. c.).

Extractum hyoscyami, U. S. P. (extract of hyoscyamus), made by evaporating the fluidextract at a temperature not exceeding 50° C., stirring constantly, until it is reduced to a pilular consistence; it is required to contain 0.22 to 0.28 per cent. of alkaloids. Dose, 1 grain (0.06 Gm.).

Tinctura hyoscyami, U. S. P. (tincture of hyoscyamus), made by macerating 1 part by weight of powdered hyoscyamus in diluted alcohol, percolating, and adding enough diluted alcohol to make 10 parts by volume; the product is required to contain 0.007 per cent. of alkaloids. Dose, 15 to 20 minims (1 to 2 c. c.).

Oleum hyoscyami compositum, N. F. (compound oil of hyoscyamus), consisting of olive or other fixed oil heated with fresh hyoscyamus leaves, and containing also small amounts of the oils of absinthe, lavender, rosemary, and sage. Uses chiefly external, as anodyne and antiseptic.

Hyoscyaminæ hydrobromidum, U. S. P. (hyoscyamine hydrobromide) [$C_{17}H_{23}NO_3 \cdot HBr$], occurring in white crystals, or as a resin-like mass with a tobacco-like odor, and possessing an acrid, nauseous taste. The salt deliquesces upon exposure to air, and is freely soluble in water, alcohol, and chloroform, but practically insoluble in ether. Dose, $\frac{1}{200}$ grain (0.0003 Gm.).

Hyoscyaminæ sulphas, U. S. P. VIII (hyoscyamine sulphate) $[(C_{17}H_{23}NO_3)_2 \cdot H_2SO_4]$, occurring in whitish crystals or a white powder, odorless, bitter and acrid in taste, and deliquescent upon exposure to the air. It is easily soluble in water and alcohol, but practically insoluble in chloroform and ether. Dose, $\frac{1}{200}$ grain (0.0003 Gm.).

Scopolaminæ hydrobromidum, U. S. P. (scopolamine hydrobromide) $[C_{17}H_{21}NO_4HBr + 3H_2O]$, occurring in colorless, odorless crystals, sometimes of large size, with an acrid, slightly bitter taste, and slightly efflorescent on exposure to the air. It is soluble in 1.5 parts of water; 1.33 parts of alcohol at 60° C. (140° F.); 16 parts of alcohol at 25° C. (77° F.), and 750 parts of chloroform, but is insoluble in ether. Dose, $\frac{1}{200}$ grain (0.0003 Gm.).

Oil of hyoscyamus, official in the German pharmacopeia, is made by warming 10 parts of olive oil and 1 part of hyoscyamus cut up fine, and previously moistened with alcohol. It is used as an anodyne liniment.

Amorphous hyoscyamine, unofficial, is an impure form of hyoscyamine, probably containing some hyoscyne. It occurs as a brown, syrupy liquid, soluble in alcohol. Dose, $\frac{1}{8}$ to $\frac{1}{4}$ grain (0.008 to 0.015 Gm.).

PHYSIOLOGICAL ACTION. — The action of hyoscyamus is that of its main alkaloidal constituent, hyoscyamine, slightly modified by that of hyoscyne. The effects, as a whole, are decidedly milder than those of belladonna, if the same amount of each drug is used, on account of the lower content of alkaloids in hyoscyamus (0.08 per cent.), as compared with belladonna leaves (0.35 per

cent.) and root (0.5 per cent.). It will have been noticed, however, that the official doses of hyoscyamus and its preparations are considerably larger than those specified for the belladonna preparations.

Hyoscyamine acts on the central nervous system precisely like atropine, exerting no effect save stimulation of the respiratory and vasomotor centers in therapeutic doses, but exciting the brain to delirium — followed by stupor — in larger amounts. Peripherally, hyoscyamine acts on the same nerve-endings as atropine, but more strongly (theoretically twice as strongly), the action on these terminals increasing with the levorotatory power of the specimen of alkaloid employed. The chief nerve-endings, depressed or paralyzed by hyoscyamine (as by atropine), are those of the oculomotor in the iris and ciliary muscles; the vagal terminals in the heart, bronchial involuntary musculature, and upper portion of the esophagus, and the secretory nerve-terminations in the glands. The results of these actions, therefore, where the drug is sufficiently pushed, are mydriasis, paralysis of accommodation, cardiac acceleration, relaxation of the bronchial tubes (especially when previously in a constricted condition), difficulty in swallowing, and diminution of the function of all glands that are under nervous control.

On the involuntary muscle tissue of the stomach, intestine, bile-duct, ureters, etc., hyoscyamine exerts the same effect as atropine, tending to stimulate motor activity, while at the same time removing any abnormal spasm in these structures when taken internally in moderately large doses, but depressing the function of the

same muscular tissue when applied to it directly.

The circulatory effects of hyoscyamine are the result of vagal paralysis, stimulation of the vasomotor center, and slight stimulation of the heart muscle directly, and are manifest in a tendency to increased pulse rate and heightened blood-pressure, followed, where large toxic doses have been used, by a secondary depression of these functions. The respiration is affected through the medullary center of breathing in the same manner as the tone of the blood-vessels. Death in animals poisoned with hyoscyamine occurs from respiratory failure.

Hyoscine paralyzes the oculomotor and vagus autonomic nerve-endings and the secretory nerve-endings like atropine and hyoscyamine, the degree of this effect increasing with the levorotatory power of the specimen of hyoscine used, but differs from them in the important particular that the brain-centers are depressed even by small doses and the respiratory and vasomotor centers by intermediate or large doses. The central nervous effects of hyoscine are thus largely antagonistic to those of hyoscyamine and atropine, whence the fact that the whole drug hyoscyamus, containing a notable proportion of hyoscine as compared with belladonna or stramonium, is more of a sedative in its central effects than the two latter drugs.

POISONING.—The symptoms and signs of hyoscyamus poisoning are extreme dryness of the fauces and throat, dilatation of the pupils, a sensation of fullness in the head, dizziness, acceleration of the pulse rate, dysphagia, muscular weakness, and a more or less pronounced muttering

delirium, followed by stupor or actual coma. Occasionally, a scarlatinoid eruption like that produced by belladonna is seen.

Treatment of Poisoning.—Chemical antidotes, such as **Lugol's solution**, **potassium permanganate**, and **tannic acid**, should be administered, followed immediately by the use of the **stomach-tube**, or, if this be not practicable, an **emetic** and **warm water**. Among the best physiological antidotes may be mentioned **pilocarpine**, $\frac{1}{4}$ grain (0.015 Gm.), and **physostigmine** (eserine), $\frac{1}{30}$ grain (0.002 Gm.), both to be administered hypodermically in one of their salts. **Morphine**, $\frac{1}{4}$ grain (0.015 Gm.), may be used to overcome restlessness and delirium, and an ice-bag applied to the head for the same purpose. Among the suitable stimulants for use in cases where marked secondary depression of the circulatory and respiratory functions appears may be mentioned **strong, hot coffee, by rectum**; **caffeine sodiobenzoate**, 5 to 10 grains (0.3 to 0.6 Gm.), by mouth or hypodermic injection, and **strychnine sulphate** or **nitrate**, $\frac{1}{20}$ grain (0.003 Gm.) or more hypodermically.

THERAPEUTICS.—Hyoscyamus is employed mainly as a sedative to the nervous system. The most common use of it is for the relief of **strangury** and **pain** or painful micturition in cases of **excessive bladder irritability**,—including that occurring in **renal tuberculosis**,—in **cystitis**, and in **gonococcal urethritis**. Where **retention of urine** supervenes in **acute cystitis**, full doses of hyoscyamus, together with opium and hot compresses or turpentine stupes to the abdomen, are of value. A suppository containing $\frac{1}{4}$ to 1 grain (0.015 to 0.06

Gm.) of the extract of hyoscyamus may be ordered at night. In **enuresis** associated with **colon bacilluria** tincture of hyoscyamus may be given in elixir of buchu at night to diminish bladder irritability; in **tabes dorsalis** the drug may also be used for the relief of enuresis (Jennings). Wellman found hyoscyamus decidedly useful in the treatment of **endemic hematuria** the result of **schistosomiasis**.

In short, dry, hacking forms of **cough** hyoscyamus acts well as a sedative and may be substituted for opium derivatives or belladonna. Powdered hyoscyamus is a not infrequent constituent of the bronchodilator cigarettes employed by **asthmatic** patients.

The drug has also been used with gratifying results in severe **whooping-cough** and **laryngismus stridulus**. It is well borne by children. Fluidextract of hyoscyamus may be given in **acute** or **chronic bronchitis** in children in doses of $\frac{1}{8}$ to $\frac{1}{3}$ minim (0.008 to 0.03 c.c.) (Fischl), or the tincture in doses of 1 to 5 minims (0.6 to 0.3 c.c.) (Abt).

Hyoscyamus is often included in purgative preparations to prevent "griping." It is a constituent of the official *pilula catharticae vegetabiles* (for the further composition of which see **COLOCYNTH**). It may be used similarly in various abnormal states of the intestine associated with colicky pain, and in **hemorrhoids** the following suppository has been recommended by Debove and Pouchet:—

R *Extracti hyoscyami*,
Extracti hamamelidisãã gr. $\frac{1}{2}$ (0.05 Gm.).
Olei theobromatis . gr. xlv (3 Gm.).
 Ft. suppositorium no. j.

In **neuralgias** of various kinds hyoscyamus has been administered, but for most cases other more effectual drugs are available. Berner, in 1911, found that the extract of hyoscyamus materially increases the narcotic action of morphine and ethyl carbonate (urethane). Hyoscyamus may be employed with benefit in mild general **nervous excitement**; where the condition is pronounced, however, hyoscine will prove more effectual. Lambert temporarily administers hyoscyamus in combination with chloral hydrate and cannabis indica to relieve persistent **insomnia** following withdrawal of morphine or opium in addicts to these drugs.

Hyoscyamine has been considerably used for the purpose of facilitating and avoiding pain in the reduction of **incarcerated hernias**. The preparation most employed has been the so-called "amorphous hyoscyamine," which consists of the combined alkaloids of hyoscyamus—true hyoscyamine and hyoscine. As this mixture varies according to the specimen of hyoscyamus from which it is obtained and is not recognized by the pharmacopeia, Waugh (1912) recommends that a definite mixture of atropine, 2 parts, with hyoscine, 3 parts, be used instead, the dose of this combination being $\frac{1}{100}$ grain (0.0006 Gm.), one-tenth of which, together with $\frac{1}{250}$ grain (0.00025 Gm.) of strychnine, is administered every five to twenty minutes until the desired effect has been induced. The same author finds this mixture of value at times in **fecal impaction** and torsion of the intestine.

Good results reported from the following combination in **neuralgia**:
 Extract of valerian, 1 part; hyoscy-

mine, 0.015 part. The formula is made up into pills, with suitable dosage, and one pill is given at 9 o'clock in the evening and a second a half-hour later; a third is given at 5 in the morning and a fourth at 8. Between the attacks quinine is administered. Bastie (*Revue française de méd. et de chir.*, No. 7, p. 161, 1904).

Amorphous hyoscyamine praised as an anodyne. It overcomes the painful spasms in the passage of **gall-stones** and **urinary calculi**, and gives almost immediate relief in all forms of **colic** without interfering with peristalsis. Usually as soon as the spasm is overcome the patient falls into a peaceful slumber, from which he awakens refreshed.

Hyoscyamine has a marked advantage over morphine for continued use, in that it has little, if any, tendency to habit formation. In **painful abdominal spasm** relief follows a dose of $\frac{1}{250}$ grain (0.00025 Gm.) within half an hour, and four or five doses of like size keep the patient at ease throughout an entire twenty-four hours. Nitroglycerin and strychnine act as synergists to amorphous hyoscyamine. Like atropine, in acute conditions hyoscyamine should be pushed, in small doses, until the full physiological effect, manifested by dryness of the mouth and throat, is reached. G. L. Servoss (*Southern Clinic*, Dec., 1910).

Hyoscyamine is also employed by many ophthalmologists as a **mydriatic**, in place of atropine. The 2 grain (0.13 Gm.) to the ounce (30 c.c.) solution generally used also causes complete ciliary paralysis, and the action is advantageous in that it persists only six or seven days, as compared with nearly two weeks in the case of atropine. Hyoscyamine may likewise be substituted for atropine where the latter is not well borne in cases of **iritis**. De Schwein- considers large doses of tincture

of hyoscyamus useful in **spasmodic heterophoria** (latent squint).

For a discussion of hyoscyamine the reader is referred to the heading **SCOPOLA AND SCOPOLAMINE**.

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HYPERCHLORHYDRIA. See **STOMACH, DISEASES OF: HYPERACIDITY.**

HYPERCHYLIA. See **STOMACH, DISEASES OF: HETEROCHYLIA.**

HYPEREMESIS GRAVIDARUM. See **PREGNANCY, DISORDERS OF.**

HYPEREMIA, BIER'S TREATMENT BY.—This method, introduced by Professor Bier in 1892, has for its purpose to increase, by causing hyperemia of a diseased area through mechanical means, the volume of blood *circulating* through it and thus enhance the bactericidal and antitoxic effects of that blood, to hasten the curative process.

[This method is quite in keeping with the trend of modern therapeutics. As Willy Meyer and Schmeiden state in their valuable work on the subject, "to increase this beneficent inflammatory hyperemia resulting from the fight of the living body against invasion is the aim of Bier's hyperemic treatment." This applies as well to inflammation, for if Bier's teachings are sound, according to the same authors: "we shall have to part with a number of time-honored views, up to the present time accepted as pathologic truths." They hold, furthermore, that "hitherto it was considered the physician's first duty to fight every kind of inflammation, since inflammations were looked upon as detrimental," and urge that "Bier teaches just the opposite: namely, to artificially increase the redness, swelling, and heat, three of the four cardinal symptoms of acute inflammation." Finally, they emphasize the fact that "the same rule obtains here as is generally applied in the case of infectious disease. There are very

few physicians today who would attempt to reduce the fever in such cases. We have learned to look upon this fever as one of the weapons of the organism in its fight against the intruder." S.]

The poultice, the hot sand bag, and similar long-tried measures owe their efficacy to the hyperemia which they induce and the benefit is proportional to the way in which they conform to the principles which Bier has found the secret of success in his methods of passive and active hyperemia treatment. The hyperemia has a curative influence only when it is the local concentration of healthy blood; hence measures to improve the state of the blood as a whole may be included in the term "hyperemia treatment." E. Joseph (*Therapie der Gegenwart*, June, 1913).

An important feature of the process is that the circulation of the blood be in no way interfered with, stasis being inimical to the results to be attained by means of the three ways in which the method is carried out: (1) By means of an *elastic bandage or band* which has for its purpose to retard the return of the blood to the heart by compressing the veins between the focus of inflammation and the heart, and suitable for diseases of the head, testicles, and extremities; (2) by means of *cupping glasses* of various sizes and shapes suitable for use upon the breast, back, pelvis, and body surface, where there exists a localized infection, an open lesion such as sinus, granulations, etc.; (3) by means of *hot air*, generated in wooden or metal boxes especially designed for the introduction of a limb, or application to a surface—the hips, back, etc.

Another feature of the treatment which requires especial care is the prevention of pain. Presence of the latter indicates that the constricting band or cupping glass is too firmly applied. It should not only be painless in application, but also relieve pain.

Experience has shown that when the two cardinal essentials: (1) free circulation of the blood in the inflamed area, and (2) absence of pain, are insured, the curative efficiency of the inflammatory process is

enhanced and that of resolution hastened. We thus obtain prevention of suppuration in a large proportion of cases; avoidance of surgical intervention, or at least substitution of a less grave operation for the severe one which progress of the local disorder might have rendered necessary: reduction of the duration of the morbid process while hastening process of repair.

The writer gives the Greek text of a passage in one of Hippocrates's works—cited later by Galen—and then gives a literal translation. Both read almost like a chapter from Bier's work on "Hyperemia." Hippocrates advises treating atrophy after immobilization of a limb, etc., by applying one or more bands to the sound part above, the constriction being tight enough to cause congestion of the blood in the part, but not tight enough to cause pain. After removal of the constricting band he orders the part to be rubbed and bathed so as to rejuvenate and promote the growth of the soft parts. The special point of this treatment, namely, that the constriction is not to be applied to the part affected, but to the sound region above, is duly emphasized, both in his works and in Galen's commentary, as also the fact that the constriction must never induce pain. He ascribed the benefit to the extra supply of nourishment from the blood thus retained in the limb. Fonstanos (*Jour. Amer. Med. Assoc.*, from *Grèce méd.*, Nov., 1908).

TECHNIQUE.—Having found Bier's method uniformly successful, Mr. Peter Daniel, Surgeon to Charing Cross, Metropolitan, and Gordon Hospitals, London, states that the unsatisfactory results often following its adoption when delegated to house surgeons and practitioners must be due, he holds, to want of familiarity with the technique and peculiarities attendant upon this plan of treatment. So clearly does he describe in Gaillard's *Southern Medicine* the various steps of the treatment, the causes of failure, and other features calculated to cut the practice of the physician that we prefer to give our readers Mr. Daniel's own version,

somewhat summarized, rather than purely descriptive matter which would not be of as great aid to them.

Causes of Failure.—As the success of the treatment practically depends upon ascertaining (1) the exact degree of hyperemia suited to each individual case, (2) the maximum duration of time the hyperemia should be maintained, it follows that a very close watch must be kept upon every case during the earlier applications of the bandage or suction glass. The failure to observe the *first effects* of the treatment *on the individual case* is the most usual cause of non-success.

The second great cause of failure depends upon the almost universal belief in the shibboleth that the vascular phenomena of inflammation are evil, and anything which tends to produce or increase any of the signs of inflammation cannot be good.

Unfortunately, pathologists still include in these phenomena the stages of stasis and thrombosis, and thus perpetuate the erroneous view that all the stages of inflammation are evil and to be combated at all costs. On the contrary, the first three stages are most essential, and without them resistance to infection is absent; they are manifest clinically by redness, heat, swelling, and almost every method of treatment which produces these clinical signs is used successfully in the treatment of diseases—fomentations, blisters, friction, massage movements.

Advantages.—Bier's hyperemia offers the following advantages: 1. It may cut short an infection or abort suppuration. 2. It always relieves pain, diminishes toxemia, reduces fever. This protects the body generally, and promotes sleep and recuperation. 3. If suppuration is present, it permits of successful treatment by means of less heroic measures, conserves bones, tendons, and joints, and obviates mutilating incisions, scars, etc. 4. It always favors an ambulatory method of treatment, in contradistinction to confinement to bed, as movements in inflamed parts may be painlessly performed while wearing a Bier bandage. 5. It shortens the stage of disease, and hastens convalescence. 6. It promotes absorption of inflammatory products and rapidly sets free necrotic tissue. 7. It is a non-terrifying

procedure, easy of application, and a most gentle manipulation. 8. It is not costly.

Indications for Use.—These are as follows: 1. Any infection, acute or chronic, above which a bandage can be applied, or over which a cupping glass may be placed, or to which dry, hot air may be applied. 2. Sequelæ and complications of infections, adhesions in joints, tendons, or other movable structures; chronic edema; sinuses and fistulæ. 3. Contractions due to trauma or paralytic lesions. 4. To aid healing and prevent infection in unavoidable operations under dirty conditions—crushes, gunshot wounds, etc. 5. To keep down exuberant granulations and thus promote rapid healing. 6. To inhibit recurrence from tissue soiling during the performance of operations, especially in tuberculosis. 7. To remove discharges from pockets. 8. To enable much earlier and painless passive and active movements in joints to be carried out. 9. To do away with plugging of wounds. 10. To clear up latent diseases. 11. To hasten the union of fractures.

Mild diabetes is not a contraindication, but diabetic furuncles and carbuncles require great caution. The suction cup should be large enough to rest everywhere on sound tissue. Here, as in all cases, the suction must never be strong enough to aspirate blood. Arteriosclerosis, as a rule, need not be regarded as a contraindication, but nervous diseases, tabes, alcoholism, etc., render the application of hyperemia treatment extremely difficult, as the disturbances in sensation deprive us of this useful guide. When the blood has been injured beyond repair by sepsis, hyperemia treatment is hopeless, but a sudden transient invasion of the blood and comparatively benign pyemic metastases are exceptionally amenable to it. Pyemic joint affections are the banner field for it. E. Joseph (*Therapie der Gegenwart*, June, 1913).

Surgical Principles Involved.—1. All pus must be given vent to. 2. But small, well-planned incisions suffice. 3. Never pack a wound with gauze, and it is rarely necessary to use a tube. If the edges of the

wound tend to heal prematurely, insert a layer of sterilized oil-silk between them. 4. If at the commencement of treating a wound or sinus the granulations are exuberant, cut them away and see the vent is free; they will not become exuberant under Bier's. 5. Avoid irritant dressings, and do not use antiseptics; employ asepsis. 6. Also avoid baths, wet dressings, and fomentations when there are open wounds. 7. Keep the surrounding skin dry and clean with alcohol, and, if necessary to preserve dryness and prevent contamination, then smear over it some thick, emollient sterile ointment. 8. Use the minimum of force; do not probe, squeeze, or swab unnecessarily, and never roughly. 9. When a Bier bandage is on, remove all other sources of constriction; a layer of sterile gauze or a sterile towel laid on the wound is the best dressing. The smaller the thickness of the dressing, the better. The ideal dressing is: Protection from contamination under a sterile towel; otherwise *nil*—free exposure to the air. 10. Where tendons are involved, as in whitlow, do not incise vertically over the front of the digit through the overlying tissues and tendon sheath (or theca), as this permits the tendon to rise out of its bed and **certainly die**; incise laterally.

General Precautions.—Certain precautions must not be violated. These are as follows: 1. Never bandage or apply pressure on diseased tissue, but on healthy parts. 2. Always bandage at such anatomical sites as enable all the veins from the diseased parts to be subjected to pressure. 3. Never produce pallor (anemia), coldness, or pain in any part. 4. Never produce any sensory changes. 5. Always remove every other source of constriction or pressure. Therefore, **remove** or loosen very freely all dressings. 6. The pulse beyond must never in the least degree be impeded. 7. Keep a constant lookout for new pockets or extension of disease. 8. If no local reaction appears, *i.e.*, in the diseased part, first apply heat for ten or fifteen minutes. 9. Do not fear increased swelling and edema in a part: they are essential. 10. Never **reapply** a Bier bandage until all the swelling and edema induced by treatment has disappeared. 11. Each case is a law unto itself.

The limb to which the constricting band is applied to induce local hyperemia must always feel as warm, if not warmer, than its mate. If the limb grows cold this is a sign that the blood is being shut off from the limb instead of collecting in it, and thus the opposite of the desired effect is realized. With small, peripheral infectious processes it is, sometimes better to apply a second constricting band close to the lesion, in addition to the one higher up on the limb, as the hyperemia induced by the latter grows less and less toward the periphery, so that the lesion may escape its effect unless reinforced by a second, looser, constricting band closer to it. E. Joseph (*Therapie der Gegenwart*, June, 1913).

The modes of application, as previously stated, consist of (1) graduated constriction by means of an elastic bandage; (2) intermittent suction of specially constructed cupping glasses; (3) the use of hot, dry air. Each of these methods will now be reviewed in turn.

The instruments employed cannot be illustrated here, as there are now hundreds of them, each one destined for a different part of the body, but any instrument maker will send an illustrated catalogue of them on request.

ELASTIC BANDAGE.—The bandage should preferably be the special bandage without selvages (which produce injurious pressure), and not very strong, so that usually several turns of the bandage are necessary to attain the desired compression, rather than one turn of a strong bandage, as it is highly desirable to diffuse the pressure exerted by the bandage; hence several overlapping turns, beginning from below, are best; but in case of need, and generally when dealing with the head and neck, the scrotum and penis, or a digit, one turn may suffice. (Bier generally uses six to eight turns, each overlapping $\frac{1}{2}$ inch.)

For the upper and lower limbs a bandage 2 inches to $2\frac{1}{2}$ inches wide is necessary, for the neck $\frac{3}{4}$ inch, for a finger alone $\frac{1}{2}$ inch, for the scrotum and penis a thin-walled (*i.e.*, soft) rubber tube serves

best (the black rubber tubing formerly used for children's feeding bottles is excellent).

Children require careful observation, and bandages in proportion to their size and frailness; also it is invariably wiser to protect a child's skin by a layer of fine Saxony flannel or lint, and to gently massage the constricted zone after the bandage has been removed. As make-shifts, rubber rings serve admirably for small parts.

Before applying the bandage the practitioner should note: (1) the degree of prominence of any veins; (2) the color and temperature of the skin; (3) if there is a wound, the color of the granulations, and the amount and character of the exudation; (4) always feel for and note the arterial pulse; (5) any special peculiarities of the case; (6) ask the patient to observe the degree and character of the pain present.

Tension of the Bandage.—As to the degree of tension which should be exerted in any given case, it is quite impossible to say. One learns by experience and by observing the precautions formulated. It is best to start with a case in which there is an open wound or sinus, such as a whitlow; this should be carefully dried and a turn of the bandage applied above. In two to five minutes, if there is a definite exudation or moisture visible, the amount of pressure is *efficient for good*; if there is no visible exudation in two to five minutes the pressure must be increased, or another turn of the bandage taken, until exudation results. One must remember that if a bandage is to remain *in situ* for many hours one must not produce a copious exudation in a few minutes. This I think usually wrong, and likely to lead to that greatest of errors, "overdoing it."

Further, whatever the character of the discharge *previous* to the application of the bandage, purulent, sanious, or what-not, the exudation which appears from the granulations in from five to ten minutes will be, must be, serous—clear, yellow, sticky. The quantity of exudation soon decreases and in many cases entirely ceases, although the wound might have been previously discharging pus freely.

The tension of the bandage should be

successfully estimated at the first or second application and maintained at this throughout the treatment; errors of judgment, however, must be corrected at all times.

If there are obvious granulations a correct hyperemia is induced when they show a bluish or deep-red appearance.

In the case of lesions other than open wounds, such as a prick or other lesion likely to lead to suppuration, or if one fears infection therefrom, as in the case of a post-mortem prick, a bandage should be worn, and the tension is now estimated on general principles, *i.e.*:—

1. The compressing bandage or ring itself must never produce local pain (if this is really unavoidable its position must be frequently changed).
2. It must relieve any pain, throbbing, burning, felt by the patient in the injured part, within from five to fifteen minutes (often this is instantaneous).

Fingers should *not* be made "blue" on the application of a bandage. They stand in a class apart and react magnificently to Bier's, and should never be made so dusky as to lose the distinct red tint, except perhaps after many hours' treatment.

Cyanosis should *not* be produced in any part of the body as an *indication* of the degree of tension of the bandage. Blueness, as distinct from reddish blue, should only be present at the termination of the period of congestion. Thus, the color of the part beyond should, after five minutes, be only just perceptibly reddish blue, *excepting* those cases where the bandage is to be retained for a short period, say, an hour, when the color reaction should be better marked.

Precautions in the Use of the Bandage.

—In any lesion of the upper or lower limb beyond the elbow and knee, except a terminal phalanx, the bandage must be applied to the upper arm and thigh; further, it should be applied well above the condyles, preferably near the axilla in the upper limb and just above the middle of the thigh. When a terminal phalanx is involved the base of the finger may be constricted.

Having observed the precautions previously mentioned, take a turn or two of the bandage. Note if the veins are now

fuller, or, if imperceptible before, are they visible now? Feel one. Is it too taut? If it can be fairly easily obliterated it is not; if, however, it feels incompressible, the bandage is too tight. At the same time ascertain the patient's feelings. Is the bandage irksome? Does the diseased part feel more uncomfortable? If the patient says he does not mind the bandage, that it is comfortable and does not obtrude on his sensations, and, further, if he says the diseased part is more comfortable, accept these points as the very best guide.

After a short time feel the limb. Is it colder at its extremity (allowing for exposure, etc.)? If it is, the bandage is too tight.

Is the skin slightly darker in hue and less pale? Is there any sensory disturbance?

Swelling and edema appear after an indefinite period, varying with the anatomy and laxness of the tissue of the part; in the scrotum and prepuce it may be considerable, but in a finger, or on the head and neck, it will and must be inconsiderable.

Above all things, avoid increased pallor, coldness, and any sensory changes. These must never result.

Thus, if the bandage is not irksome, if pain is relieved, if the veins are more prominent without being incompressible, if the limb retains its warmth (sometimes feels hotter), and, later on, some edema appears, and no loss of sensation occurs, the bandage is at a correct tension, and should be fixed by a safety pin, to be replaced later by a piece of tape sewn on to the last turn. Mark the turns of the bandage for future guidance, and see they correspond when replacing it.

In the case of the *head* and *neck* an elastic fillet $\frac{3}{4}$ inch wide is made, encircling the neck once, to be worn as low down as possible. It may easily be worn unperceived under the collar in either male or female. After the correct degree of tension is ascertained a hook and eye, or a stud and buttonhole, fixes the turn.

If the neck is plump sufficient pressure will be exerted by the bandage on both the cutaneous veins and the internal jugular, as, owing to the contour of the side

and back of the neck, the fillet appears to sit most comfortably just where the trachea begins to sink, and sufficient pressure for comfort is taken off the trachea by the sternomastoids.

If there is but little subcutaneous tissue or the trachea is relatively prominent, a flat pad about the width of and fitting over the sternomastoids, made of layers of flannel (or soft felt) of sufficient thickness and sewn together, must be used under the fillet.

The sensation of being choked, and interference with deglutition, must never be pronounced; and as the wearing of a bandage is occasionally only possible at night, it must never prevent sleep; in fact, it *must not be irksome*. At first all patients tend to resent the sense of even slight tracheal compression, and complain of fullness in the head, but a little patience soon enables them to overcome these unruly emotional sensations.

If the bandage "rides up" two tapes may be sewn to it and passed under the axillæ. In this way, for postoperative purposes, abscesses, glands, and sinuses as low as the cricoid may be treated, and if unilateral a figure of eight round the neck and axilla may be used for glands even lower than this.

The external jugular or the temporal vein serves as a visible guide to the surgeon.

Similarly with *shoulder* and *upper-arm* lesions high up, the elastic bandage may be supplemented by a soft, wide pad placed over the situation of the subclavian or axillary vein, *i.e.*, it may be placed above and touching the clavicle in the hollow of the root of the neck or below the clavicle in the hollow just internal to the deltoid, the bandage, which has a tendency to slip off the shoulder, being kept in position as follows: A soft scarf formed of a skein of wool (or other suitable material) loosely fitting the neck is worn, and through its bight the elastic bandage is passed; in addition, two tapes are fastened to the elastic bandage where it crosses the anterior and posterior axillary fold, and tied round the chest under the opposite axilla.

By regulating the loop of the scarf, the axillary tapes, and the tension of the elas-

tic bandage, the latter may be kept at any spot desired, and the resultant compression regulated by the principles already mentioned.

An Esmarch tube tourniquet—*i.e.*, a soft, big-bore rubber tube—is often used for the shoulder, the axillary folds being protected by lint or wool.

The *hip* cannot be influenced by a Bier bandage.

In the case of the *penis* and *scrotum* soft-rubber tubing serves best, but a rubber ring may be improvised. The penis alone or the penis and scrotum may be constricted together for penile affections; the scrotum alone for testicular and scrotal affections.

If only the anterior one-third of the urethra or the prepuce and glans are involved, the penis is slightly pulled away from the pubis and the ring slipped on (I find suitable broad, flat rings difficult to procure), or the tubing is tied in place (see later).

If the scrotum is to be included, the tube, 8 inches long, is placed on the bulb behind the scrotum, and brought round to the dorsum of the penis; here a piece of tape is laid, across the tape the two ends of the stretched tube are crossed, and the point of crossing tied by the tape. In an institution a bulldog clip may be used.

To treat the *testicles* the scrotum is gently pulled upon so as to form a pedicle, and the ring or bandage applied while so stretched.

If the bandage is placed on the penis alone the urethra beneath should be protected by means of a layer of soft material, but when the scrotum is included the latter serves this purpose; the scrotum should invariably be protected by a layer of lint (the pedicle may be formed by a turn of the lint).

The tension is estimated, as before, on general principles and by observing the fullness of the cutaneous veins; also by the relief afforded. The glans early becomes congested. In testicular affections considerable edema of the scrotum must be produced after some hours of constriction, else the benefit afforded by the bandage appears to be very small.

In the case of early gonorrhea the con-

gestion of the glans should be fairly marked, and the bandage may be worn for ten or eleven hours continuously, day and night, micturition not being interfered with.

Take care the pubic hairs are not caught up in the bandage, or free them.

On first applying, wipe off the urethral discharge and observe carefully that in a short time it becomes thinner in consistence and clearer, and in a good reaction a clear, copious mucoid exudation will appear in five to fifteen minutes. At the end of this time the turgidity of the preputial veins and the glans should have ceased to increase, and there should be neither pain nor discomfort, else the bandage is too tight. Should the bandage become irksome, or micturition be impeded, it must be loosened.

The most suitable drug treatment to combine with Bier's is a mixture containing:—

R *Hexamethylenaminæ* gr. v (0.3 Gm.).
Tinct. hyoscyami ... ℥xx (1.25 c.c.).
Aq. chloroformi,
 q. s. ad ℥j (30 c.c.).

To be taken four times a day.

Also restrict the liquids so as to give the organ physiological rest, and never syringe.

General hygienic treatment and ample physical rest are required.

In posterior urethritis (superficial prostatitis) this method must be replaced by a suction glass to the penis and perineum.

In *breast* cases (abscess, sinus, interstitial and puerperal mastitis, etc.), if the organ is sufficiently lax and pendulous to make a pedicle, the bandage serves admirably, it being retained in place by tapes carried around the thorax and over the clavicle.

Retention of the Bandage.—As to how long the bandage should be retained; as a general guide: (a) The more *acute* the infection, the *longer*—*i.e.*, the more continuously—the bandage is worn; the maximum duration is eleven hours out of every twelve, then one hour's intermission.

The intermission is partly determined by observing the length of time necessary to permit the whole of the *induced* swelling

and edema to disappear. Slight elevation may be utilized to facilitate its removal. Any time over an hour must be deducted, and it will be found in practice that ten hours is the longest time a bandage may be worn.

In some cases, after from four to eight hours, the patient cannot longer tolerate the bandage, although no other evidence for its removal may exist. A trial of a new position may be made, and, if successful, the full time may be taken, but usually it is wiser to remove the bandage, and either make the time and tension it was tolerated the orthodox dose for that case, or else slightly decrease the tension in future and observe its effect.

(b) The *more chronic* the infection, the *shorter* the application; this applies chiefly to tuberculosis. The minimum dose per diem is one hour, the average two to six hours, either continuously or at two or more intervals. Mr. Daniel's own custom with regard to tubercle is to apply a lesser degree of constriction than if the case were a suppurating or septic case, and to wear the bandage one or two hours two or three times a day, taking particular note of the pulse and temperature, as well as the other conditions, to guide treatment.

The sensations of the patient are most important, the relief of pain and the ability to permit slight passive movements while the bandage is *in situ* being most helpful both as guides and therapeutic measures. It is very seldom necessary to induce a well-marked color reaction in tubercle, but if it is sought the tuberculous area should be fomented or bathed in hot water for ten to fifteen minutes, or a hot-air douche given for ten minutes before applying the bandage.

Occasionally edema is easily obtained, and is of good prognosis.

It is with regard to tuberculosis that the most divergent results are obtained, and in which the individual factor of the practitioner tells most.

The removal of all carious teeth and the cure of suppurating foci are highly essential, while a richly nitrogenous diet should be insisted on, supplemented with raw meat juice three or four times a day, which will do more to increase the resist-

ing power of patients than the use of tuberculin.

Open-air treatment, especially the ambulatory methods which afford change of view, gives stimulus to the mind and the ability to seek and obtain relief from monotony, and which, with the muscular movements entailed, are the fundamental reasons why "open-air" treatment does good.

SUCTION GLASSES.—Bier's suction glasses are simply cupping glasses, suitably shaped and adapted, with a hollow stem for the attachment of a special device for aspirating the air, and thus producing suction.

The varieties of shape, size, and finish are now legion. In the case of very large glasses, enclosing whole limbs, and also occasionally on small glasses for treating the penis or fingers, rubber diaphragms or cuffs are fitted over the rims, and through a hole in the center of the cuff the limb is passed so as to secure an absolute air-tight fit; it may, indeed, be necessary to secure the cuff firmly to the limb by a turn or two of bandage.

For orthopedic purposes where contractures exist, and to effect movements in ankylosed or stiffened joints, a result which is obtained with wonderful freedom from pain, very elaborate glasses with interrupted spaces, or windows, covered in by strong rubber sheets (diaphragms), and containing intricate mechanical apparatus, are used; these, however, are too complicated to describe within the limits of this article.

There are two methods of producing aspiration:—

The simplest is by means of a rubber bulb attached to the hollow stem of the glass, the degree of aspiration, and consequently of suction on the tissues, being in proportion to the degree the rubber ball is pressed when the glass is applied over the diseased area.

The other method is by means of a suction pump (a thoracic aspirating pump) attached to the glass by means of strong rubber tubing. On the rubber tube a three-way stopcock is fitted, so that the degree of suction can be regulated to a nicety and the apparatus removed without discomfort or difficulty.

Special-shaped glasses are available for different parts of the body, and the rims are made so as to secure close apposition to the varying contours of the part, accurate apposition being a *sine qua non*.

Where the rim may, of necessity, have to rest on bone on one side and soft tissues on the other, pneumatic rubbers, similar to those on the face-piece of anesthetic apparatus, may be attached to the glass.

Size of Glass.—The diameter of the glass should exceed that of the diseased area, but it is not desirable that it be more than will easily embrace the diseased part, *i.e.*, the pressure of the rim must be exercised on healthy tissue.

In this connection it is necessary to see that the thickness of the rim is considerable, so as to diffuse the pressure, as the rim actually performs the same mechanical function that the elastic bandage does—namely, it compresses the nervous system, and what applies to the bandage applies equally to the glass.

Degree of Suction.—When a glass is applied under suction the tissues are drawn into it, forming a dome-like protrusion, reddish blue or mottled in color. Color reaction is always marked in this method, and indicates considerable venous obstruction, which, if long continued, would be injurious; hence the method of treatment is carried out *intermittently*.

If the suction is too great (or too suddenly applied) the skin may become a very dark blue and petechiæ may appear; also pain is experienced, and it is by estimating the degree of discomfort—*i.e.*, its absence—and never losing the *reddish* tinge in the skin that in a short time the practitioner arrives at an estimate of the correct degree of suction.

Real pain should never occur, but in very inflamed parts the feel of the suction may amount to discomfort, which, however, in a minute or two quite disappears.

(1) A moderate-sized "dome," (2) a reddish-blue color, and (3) an easily tolerated but definitely felt suction are the trio of signs one goes by. These are added to in the case of furuncles, open wounds, etc., by observing that the serum which exudes is *not* blood-stained or rapidly ceases to be blood-stained.

The dome of tissue should *never be, or become, pallid*, which, of course, indicates interference with the arterial supply (anemia). Pallor and Bier's are incompatible.

With certain open wounds so readily do the granulations bleed that a definite pink tinge in the exudation may be unavoidable, but as they become healthier this slight bleeding is more easily avoided.

Application.—If the glass is a small one, with rubber bulb, squeeze the bulb about half empty, apply the rim firmly on healthy skin over the diseased area, which should be as near the center as possible; gently relax the bulb, and note the dome of tissue as it develops.

If the suction does not produce pain, and the dome is a reddish blue, all is well. The size of the dome is not always a suitable criterion, as it varies with the density of the tissue and the type of inflammation present. The glass is allowed to remain on for five minutes and then removed. To take it off gently squeeze the bulb; the dome disappears, and suction ceases. The glass is at once cleansed by wiping it, and immediately placed in boiling water for one minute, then taken out and placed on a sterile towel to cool.

Three minutes after its removal the glass is reapplied.

Thus, suction is maintained five minutes, then an intermission of three minutes; repeated for six applications, the séance consists, therefore, of thirty minutes' suction and fifteen minutes' intermissions. But a slavish adherence to this dosage is unnecessary.

Treatment is usually carried out once daily, but under certain conditions it is wise to make three to six applications in the morning and again in the evening, the result of treatment and the physical condition and progress of the patient determining this question.

As both bandage and glass protect the body generally from toxemia, which is proved by careful note of the pulse and temperature during the after-treatment, a more frequent application of the glass with a slightly lesser degree of suction is preferable. The patient can easily be taught to carry out the evening or morning application.

With the larger glasses the pump expels the air while the glass is *in situ*, rapidity of suction being avoided, and an accurate degree of suction can with certainty be obtained; by gently opening the stopcock air is admitted at will, and thereby the pressure varied from time to time, or diminished if an excess of aspiration has been induced. The air is gently admitted also to remove the glass.

Precautions.—Certain details are important.

That of infection and reinfection comes first. By the fomentation method of treating furuncles and suppurating wounds it is unquestionable that the practitioner prepares the adjacent skin by *soddening it*; then there is conveyed to it virulent bacteria from the original focus, by spread of the discharge along the surface of the fomentation. Treatment thus perpetuates the original trouble; likewise with acne and other lesions of the skin. With a Bier glass similar damage may be done unless (a) the rim is broad and smooth, (b) scrupulously sterilized by boiling, and (c) the skin is protected from an exudation which may exude and contaminate its surface. This is best avoided by freely smearing the skin around the wound with an aseptic and sterilized unguent, preferably vaselin. The unguent also helps to procure a perfect airtight fit. It may be removed, if necessary, by ether and alcohol.

A vessel of boiling water must always be at hand.

After-treatment.—Experience emphasizes the avoidance of both wet dressings and antiseptics. Therefore, a *dry sterile gauze* dressing without any wool, and the minimum of bandaging, is best. If wool is essential on account of copious discharge it should not be a thick pad. Free circulation of air appears to me to be highly desirable, and if a patient can be so managed as to do *without any dressing* at all, the discharge being mopped up from time to time with a sterile swab, great benefit will accrue. Thus, a minimum of dressing material frequently renewed should be aimed at. At night a gauze dressing must be worn. Keeping the surrounding skin dry by the above measures, supplemented by occasional swabbing with alcohol, is an

excellent adjunct to the treatment of all wounds. Toward the later stages, or if it is essential for the patient to be about, —*i.e.*, out of house,—the gauze dressing, or a dressing of some thick, non-irritating sterile ointment, spread on lint with a hole in the center for the discharge to pass through, covered by sterile gauze, acts very well. By sterile gauze is meant one free from antiseptics and sterilized by heat.

If an abscess is to be opened a small but *efficient* incision or puncture suffices, and the glass may be applied at once. The bleeding soon ceases, and the pus and minute sloughs are removed rapidly. Within a few days the discharge diminishes markedly, or even ceases, and healing is rapid.

To keep the orifice open: Do not pack with gauze, but pass a strip of sterilized oiled silk or rubber tissue between the edges of the wound. In case of large abscesses a free opening should be made, so as to obviate wearing a tube; healing takes place much more quickly under Bier's methods.

The question of boiling the rubber bulbs and tubing is to be treated on common-sense lines; if they are soiled, certainly they must be.

It is maintained that the physiological effect (hyperemia) of a suction glass extends to a depth of 2 inches and, therefore, can reach any point in the limbs and parietes and, also, certain viscera.

There is no department of physic in which either the bandage or glass will not be of service; medicine, surgery, and gynecology offer many conditions for their employment.

HOT AIR.—Hot air may be employed to induce hyperemia in two ways: 1. In a hot-air chamber. 2. As a hot-air douche.

Dry heat generated by a gas ring, a Bunsen or paraffin lamp, electric bulbs, a spirit lamp,—in fact, any form of flame,—may be used as the source of heat. This is conducted by a funnel of sheet iron or block tin placed over the flame, but raised above its level—*i.e.*, with a definite interval between.

HOT-AIR DOUCHE.—To the end of the funnel is fitted a tube, 2 or 3 feet long, which gradually tapers to a nozzle, and

the hot air as it issues is directed to impinge on the part to be treated, the heat being regulated: (1) partly by the size of the flame; (2) partly by the diameter of the funnel; (3) partly by the size of the interval between the flame and the funnel; (4) but chiefly by the distance the nozzle is held from the skin.

The degree of heat desired is the highest the patient can bear without pain or burning. An intelligent tinman or blacksmith can easily make the funnel; the tube for douche purposes must be attached to the end of the funnel by a universal joint, so that the stream of hot air can be made to follow the course of a nerve or be otherwise moved about.

THE HOT-AIR CHAMBER.—This is made of wood, preferably free from resinous constituents, which might take fire or liquefy and burn the patient, and well seasoned. It should be too large rather than too small. In the ends are holes lined with felt, prolonged as flaps, which can be bandaged on the limbs.

The roof should be made as a lid, and contain a sliding shutter for ventilation and evaporation, especially the latter, as the limb perspires freely, and the chamber should be kept dry, else the moisture interferes with attaining a high temperature and dry air.

The funnel is let into one side of the chamber, and to protect the limb from the hot air impinging directly on to it, and to diffuse the heat, a partition suspended from the lid, but not reaching the bottom, should be fixed.

The toes and highest points in the box are especially affected by the heat, and it is always wise to wear a hood over the toes, made of thick flannel or felt, else they become extremely painful.

Technique.—To apply the treatment the lid is raised, the limb passed into or through the box, and the felt cuffs bandaged on; the limb must lie comfortably. The ventilator is opened very slightly. The lamp or Bunsen is now lit and then brought under the funnel, and not too close to it. The temperature must be raised gradually, but neither pain nor real discomfort must be produced.

Burns are easily produced either by contact with the wood, or when the escape

of moisture is not sufficiently free, and are not noticed when produced. Endeavor to ascertain the highest temperature which is best borne, and maintain it by regulating the flame, and its distance from the funnel, and the width of the ventilator.

Tallerman baths when available are ideal hot-air baths. The dose of douche is twenty to forty minutes daily, according to the effect upon the disease. It should be started and finished gradually.

In the hot-air chamber a longer time may be given if it is well borne. After hot-air treatment in the chamber the ventilator should be widely opened and the temperature gradually reduced, the limb well dried and not taken out too suddenly.

Hot-air treatment should *always be followed by massage* and the part swathed. Occasionally a short exposure to douche or chamber may precede a Bier bandage.

A little ingenuity only is necessary to devise boxes suitable to place over the body or hips and shoulders. A few electric light bulbs carried under a cradle well covered with blankets make quite a good chamber.

Indications.—The indications for hot air are: 1. The period of convalescence from acute processes and to remove the ill effects of inflammation, trauma, and operative measures affecting joints more especially. 2. Also the indefinite lesions classed under neuritis and neuralgia. 3. Any painful parts.

Mr. Daniel, in closing, warns practitioners not to use the hot-air methods as a routine in tuberculous affections.

The writer has become convinced that the profession has been on the wrong track in combating inflammation. By the end of another decade physicians will believe, as a matter of course, that antiphlogosis, in its strict application, was one of the most serious mistakes in the history of medical science. The writer has long regarded inflammation as something useful, and promotes instead of fighting it. He has applied "congestive hyperemia"—which he regards as the best of all means known to date for increasing existing inflammation—in treatment of 110 cases of

acute or subacute **suppurative inflammations**, after his experience with the chronic had proved so favorable. Each year has extended the sphere of this method of treatment until now he applies it in all cases of accessible suppuration and his results have been eminently favorable. Bier (*Münch. med. Woch.*, Jan. 31, 1905).

Report of 150 cases of acute inflammation at Garré's Clinic treated by artificially induced hyperemia. Case in which the constriction was applied without due medical supervision, with the consequence that the arm became permanently contracted, with chronic edema and inability to use the fingers, not from necrosis of the tendons, but solely from the excessive and overlong application of the constriction. Treatment with congestive hyperemia requires much closer medical supervision than any other method of treating acute inflammations. Physicians who have not the time, the patience, nor the opportunity for such close supervision should not attempt to treat a patient by congestive hyperemia, as they are liable to do more harm than with the knife. Stich (*Berl. klin. Woch.*, Bd. xlii, Nu. 50, 1906).

SPECIAL THERAPEUTICS.—The advantages of the various procedures just described have been recorded by a host of investigators. This field of application is very great, one or the other of the procedures being valuable in surgery, medicine, and the various specialties.

Surgery.—In this field disorders which tend to include suppuration stand out prominently among those in which the use of the Bier method has been praised.

An experience with 35 cases has shown that passive congestion may give extremely fine results, especially in case of **felons** and **furuncles**. On the other hand, it is not a general panacea, and it may fail. In case of severe **phlegmon** it must be applied with caution and with conscientious supervision of the case. Colley (*Münch. med. Woch.*, Bd. liii, Nu. 6, 1906).

Success in the treatment of 119 cases of local inflammatory and suppurative conditions by means of Bier's method. Among the cases were 58 **phlegmonous abscesses**, 3 ordinary **abscesses**, 12 **panaritias**, 7 cases of **acute suppurative tenosynovitis**, 6 of **acute suppurative lymphadenitis**, etc. The method of Bier not only inhibits the growth of bacteria and reduces inflammation, but considerably relieves pain. Gramenitsky (*Roussky Vrach*, Sept. 9, 1906).

The writer reports 142 cases of **carbuncle**, **phlegmon**, **mastitis**, **articular rheumatism**, **osteomyelitis**, etc., treated at St. Petersburg by Bier's technique of arterial or venous hyperemia. The method demands constant medical supervision, but when conditions are favorable it gives good results in a shorter time than any other therapeutic method. Heinrichsen (*Archiv f. klin. Chir.*, Bd. lxxxvii, Nu. 1, 1908).

Among the surgical disorders in which the method has been most useful may be mentioned: **Furuncles**, **carbuncles**, **abscesses**, **acute lymphadenitis**, **infected wounds** and **inflammatory processes**, **fistulæ**, **primary and metastatic parotitis**, **puerperal mastitis**, **arthrodial infections** (**gonorrheal arthritis**, for instance), **perforative wounds of joints**, **felon** and **tendinous phlegmons** (**palmar abscesses**, for example), **acute and recurrent osteomyelitis**, **erysipelas**, **infected wounds**, **compound fractures**, **inflammatory flat-foot**, **scoliosis**, **varicose veins**, **gangrene** and **frost-bites**. Closely related to the foregoing are the various manifestations of **tuberculosis**, **osseous**, **glandular**, **tendinous**, **peritoneal**, etc., all of which are greatly benefited.

The writer used Bier's method in over 300 cases, about 200 of which were tuberculous. **Chronic inflammations of the joints** of the knee, hand, and foot were markedly benefited and in many cases the swelling entirely disappeared. This was especially noticeable in children, and the pain and spasm often subsided after

a few applications. In other cases the condition grew worse and operation became necessary. The methods employed in the various diseases were as follows: In **tuberculosis** the constricting elastic bandage was applied during the first week twice daily and allowed to remain in place four to five hours. After this it was applied less day by day, until it was in use only one hour daily. Active hyperemia (hot air, etc.) was not used, but injections of iodoform were given in the presence of **joint effusions** or unopened **abscesses**. Large abscesses were incised and fistulae curetted. In advanced cases resections are, of course, indicated. In **gonorrheal rheumatism** the elastic bandage should be left in place at least from eight to twelve hours daily. After the fever and the pain have subsided, in addition active hyperemia is employed for the absorption of effusions—a daily session of an hour in the hot sand or electric light bath. In cases of **chronic joint adhesions following trauma or inflammation** the bandage is applied twice daily for an hour, in addition to massage and exercises, and a hot-air bath every third day. For **joint inflammations due to chronic rheumatism**, he prefers active hyperemia by the hot-air or the electric light bath. For **incomplete callous formation**, aside from massage and exercise, the passive hyperemia may be used for two hours daily. **Freezing, frost-bites**, and the like are benefited greatly by the application of the elastic bandage twice daily for from one to two hours. Habs (Münc. med. Woch., June 2, 1903).

Results of treatment on this principle of 105 patients with **carbuncles, felons, phlegmons, infected wounds, lymphangitis**, and similar affections. Its chief advantages are the doing away with the necessity for large incisions, with resulting scars, and for tamponing, while it reduces the length of treatment and prevents serious functional disturbances in **joint and tendon-sheath affections**.

It is indispensable, however, that Bier's directions should be closely followed, and that the application of the constricting band should always be closely supervised by the physician. It should never be left to the judgment of the patient or nurse. If medical surveillance is not possible, then this method of treatment should not be attempted. Küttner (Münc. med. Woch., Bd. lii, Nu. 48, 1905).

Details of 65 cases of **acute inflammations** treated by Bier's method of passive congestion or congestive hyperemia. It is best to allow as wide a space as possible between the lesion and the constricting band, which Bier also emphasizes. Von Brunn (Beiträge z. klin. Chir., Bd. xlv, Nu. 3, 1906).

On the extremities the desired result is obtained by applying a tourniquet to the limb. On the trunk it is necessary to use aspirating or suction apparatus. In **mammitis** a broad-rimmed glass fits over the breast around its base, and a vacuum is created with an air pump connecting with a cannula through the rubber stopper in the top of the cup or jar. When there is distinct fluctuation in the abscess it is opened with small incisions after local anesthetization with an ethyl chloride spray, and the glass bell is applied at once. The immediate relief of the pain in all cases of mammitis is one of the greatest advantages of this method of treatment. It aborts early cases and prompt recovery is the rule. Three weeks was the average duration of the 15 cases thus treated, including 13 of **puerperal infectious mastitis**. Klapp (Münc. med. Woch., Bd. lii, Nu. 16, 1905).

The writer has used passive congestion in more than 150 cases and always with increasing satisfaction. He applies it **after operations** when the slightest indications develop suggesting the possibility that healing may not be by primary intention. The prompt application of the constricting band or of the suction cup

was invariably followed by the subsidence of symptoms of irritation when the wounds were in tissues that had not suppurated before the operation. In the frequent operations for crushed fingers of factory operatives, the wounds are much soiled, but they heal by primary intention when passive congestion is energetically applied. N. Kaefer (Centralbl. f. Chir., Bd. xxxiii, Nu. 10, 1906).

Inflammation does not spread if the part is loosely constricted from the general circulation. This technique might be combined with the Bier technique, but it has the advantage that it does not require the close supervision necessary with the latter. The healing of fistulas and abscesses past the acute inflammatory stage is promoted by pressing the walls together at the bottom of the cavity. Heermann (Deut. med. Woch., Bd. xxxii, Nu. 18, 1906).

The treatment of frozen parts in 150 cases demonstrated beyond question the advantages of the various procedures. Superheated air acts most promptly and powerfully, and is especially effectual in chronic processes, but constriction hyperemia is best adapted for the acute cases. Hyperemia is contraindicated in case of general freezing, as general hyperemia drains too much blood away from the heart to the periphery and heart-failure is the result. Ritter (Münch. med. Woch., Bd. liv, Nu. 19, 1907).

Bier's passive hyperemia is a valuable physical aid in the treatment of **tuberculous, gonorrheal, and acute suppurative inflammations**. It is indicated, and without incision, in pure **fungus**, without inclination to softening, in all gonorrheal inflammations, and in all beginning acute inflammation. It is still further indicated in those cases in which, in spite of a wide incision, the granulating wound is unhealthy and the sepsis has not diminished. It is not effective in infiltrated and fibrous inflammatory

tissue (as in many streptococcic phlegmons), in glands without complete softening, lymphadenitis, and lymphangitis, in many cases of bone infection, erysipelas, and diabetic phlegmons. Lossen (Deut. Zeit. f. Chir., Bd. xcvi, 259, 1909).

Malignant furuncle of the face, particularly of the upper lip, is usually treated by means of incision or excision; more rarely by the use of caustics. Owing to the great danger of thrombosis of the cerebral veins, many authors recommend expectant treatment. The writer, assistant of Dr. Bier, reports 12 severe cases of **furuncle of the upper lip**, and 24 cases of a more mild nature, in which the lower lip and other parts of the face were affected. All the cases were cured by the treatment in the course of four to six days. The technique of the treatment is as follows: An elastic band, 3 cm. wide, is applied around the neck as low as possible and fixed at the back by a hook and eye. It need only be drawn moderately tight, as stasis is easily produced in the neck with only a moderate amount of constriction. A compress may be placed within the band. The band should be kept on from twenty to twenty-four hours. The inconvenience experienced soon passes off. The face becomes swollen, and especially the affected parts. At the end of from one to three days of hyperemia the inflamed area softens and suppurates freely, then the discharge diminishes, and is followed by the process of healing. Applications should be made each day, the duration being gradually reduced, till the inflammatory process is at an end and repair of the tissues commences. Keppler (Münch. med. Woch., Nu. 7-8, 1910).

The suction method acts well in circumscribed inflammation, such as **carbuncle, abscess, and bursitis**, and gives particularly good results in **mammary abscess**. It is also useful in obstinate **septic sinuses**. It acts less favorably, and in some cases prejudicially, in spreading inflamma-

tion. It gives good results in **gonorrheal arthritis**, but should be used with caution in joint suppuration. It is contraindicated in erysipelas, and is of uncertain value in acute osteomyelitis. It acts beneficially in **infected wounds**. MacEwen (Edinburgh Med. Jour., Nov., 1910).

No physician skilled in the technique would be willing to do without it now in treatment of **tendon-sheath phlegmons, mastitis, furuncles on the face, and carbuncles, etc.** **Tuberculous lesions** may require it to be kept up for years to be finally successful, and consequently it is foolish to commence it with persons who are unable to devote the necessary time to it. For **tuberculous joint lesions** the constricting band should be applied for two hours a day, drawn just tight enough to induce considerable edema, with possibly a slight livid aspect of the limb. No pain should ever be caused by the constriction; the prompt relief of existing pain is one of the great advantages of the method. **Tuberculous abscess** should be punctured and the contents aspirated with a vacuum cup, suction hyperemia being maintained in this way, with intermissions, up to a total of thirty minutes a day, until the abscess has entirely healed over; the constricting band of passive hyperemia can be continued at the same time for two hours a day. The method is best adapted for the hand, foot, and elbow; the shoulder is less favorable for it and it cannot be applied to the hip-joint at all. **Lesions in the testicles and epididymis** are also amenable to this treatment. E. Joseph (Therapie der Gegenwart, June, 1913).

Internal Disorders.—Various general diseases such as **acute and chronic articular rheumatism, arthritis deformans and gout, diphtheria, pulmonary tuberculosis, bone metastases, following typhoid; lumbago, and seasickness** have also been found to yield more or less satisfactorily to the hyperemia treatment, used in such

a manner as to induce hyperemia in the area which bears the brunt of the disease. Various **neuroses, cerebrospinal meningitis, paresthesias, writers' cramp, etc.**, are also stated to have been favorably influenced.

Bier's method is applicable to many internal and general disorders of non-surgical nature. Prominent among these are **cardiac affections, pulmonary diseases, skin diseases, diseases of the stomach and intestines, disorders of the vasomotor and trophic nerves, and disturbances of metabolism** such as **anemia, obesity, gout, and diabetes**. While the differentiation between active, or arterial, and passive, or venous, hyperemia is well founded and to be adhered to, it is frequently difficult to separate the two forms in practice and undoubtedly in many cases the results obtained are due to a combination of the two. In the treatment of internal disorders it is chiefly active hyperemia that comes in question, though at times the other type is also of service. Hot air is one of the best means of inducing arterial hyperemia, and the application of hot water in various ways is also an effective and convenient method of securing the desired effect. In some cases, as in **gastrointestinal affections**, hot beverages are of service, while in others hot local baths or compresses may be employed with advantage and furnish a means of treatment that is easily regulated in point of duration, intensity, etc. The action of hot-water applications is like that of the hot air and is characterized by local relief from pain, inhibition of bacterial growth, resolution and absorption of exudates, and nutrition of the tissues. Lewandowski (Berl. klin. Woch.; Diet. and Hyg. Gaz., July, 1908).

In **acroparesthesia** congestive hyperemia improves the nutrition of the sensory nerve-endings distributed in the skin of the extremities; the nerves suffer in this infection from insufficient supply of blood

caused by contraction of the blood-vessels. In **neuralgia** the blood-vessels undoubtedly play a certain rôle in the causation of a degenerative state of the peripheral nerve. Not all of the cases of the first series gave uniformly satisfactory results. Four patients made a complete recovery, 7 showed great improvement, 1 (tic of the neck) failed. The writer makes a further report on 6 additional cases of neuroses, treated with favorable results by the use of Bier's method. The cases are **acroparesthesia**, **writers' cramp**, **telegraphers' cramp**, **brachial neuralgia**, a **paroxysmal cramp**, and **paresthesia**. Alfred Gordon (Va. Med. Semi-monthly, Sept. 25, 1908).

The writer has been applying constriction or suction hyperemia as a routine measure in treatment of **gall-stone** and **liver troubles**, **sciatica**, **leg ulcer**, and **asthma** during the last five years, and has been much gratified with the good effects obtained. In more than 100 cases of gall-stone and **catarrhal liver enlargement**, the application of a large suction bell over the liver region gave almost immediate relief, the pains and the swelling of the liver rapidly subsiding. The effect is very striking in **gall-stone colic**, the whole attack being aborted by the action of the large cupping glass, so that now he always applies the suction bell or hot-air box before giving morphine even in the severest attacks from **gall-stones** or **kidney-stones**; it frequently renders the sedative unnecessary. In some cases the pain increases under the suction bell, and the temperature rises; when this occurs the trouble is invariably empyema of the gall-bladder, and this differentiates the conditions at once. In **kidney-stone colic** and **sciatica** the suction bell gives the greatest relief, the bell being pressed firmly down over the kidney or the sciatic foramen. In a number of cases of **diabetic polyneuritis** in which the pains had resisted all other measures, they subsided under a con-

stricting band. Great care is necessary to keep changing the position of the band, moving it up or down and constantly instructing the patient to warn of the slightest sensation of discomfort. Weidenbaum (Med. Klinik, July 31, 1910).

In the treatment of **felons** and **infected wounds** of the **fingers**, the writer found obstruction hyperemia to be more comfortable to the patient, and more beneficial as well, when the bandage was placed about the forearm than when about the affected finger. Suction hyperemia has given better results in such cases than has the obstructive type. S. W. Moorhead (Therap. Gaz., April, 1910).

Dry heat acts more superficially and slowly on the tissues, owing to its comparatively slight penetrating power, while moist heat, on account of its remarkable penetrating power, rapidly passes through the organs of the body, and of all methods of application the steam douche is most effectual according to his experience. The steam douche has had but scant consideration in the literature to date, and yet its field is broad. The writer applied it to fully a third of all his patients with internal diseases, and ascribes a large part of his success to it, emphasizing the excellent results obtained in 24 cases of disturbances in the liver or biliary passages, especially congestions and stasis, **cholecystitis**, **catarrhal jaundice**, **gall-stone** trouble, and **diffuse inflammation** of the liver. The steam douche puts an end to the cramp of the vessels causing the **colics** and thus cures the pain. The pressure is about one atmosphere and a half, and he generally follows it with an alternating hot and cold fan douche. When there is persisting tenderness he applies a hot coil to the liver region through which water at a temperature of 45° C. (113° F.) is constantly running. His experience with the steam douche was equally favorable in 5 cases of **kidney-stone**

colic. The steam douche was applied for half an hour and followed by a bath at 35° C. (95° F.), all co-operating to relax the spasmodic contraction of the vessels. The steam douche frequently takes the place of and renders morphine unnecessary. The same principles have proved equally effectual in treatment of motor and secretory gastric neuroses, nervous dyspepsia, and gastralgia, acute and chronic gastrointestinal catarrh, and for atony and constipation. Hot packs to the stomach region with a hot coil act as a specific for nervous vomiting or dyspepsia and gastralgia, but the steam douche proved more effectual in the other conditions supplemented by massage and exercises. Klug (Jour. Amer. Med. Assoc., from Deut. med. Woch., May 25, 1911).

Ophthalmology, Otology, and Laryngology.—The Bier method has been found useful in various inflammatory disorders of the eyes, especially in acute dacryocystitis, parenchymatous keratitis, sympathetic ophthalmia, blepharitis, conjunctivitis, and sty, and also in progressive optic atrophy. It proved helpful also as to otology, in some cases of otitis media, even with mild mastoiditis, though not in the chronic forms; in rhinology and laryngology, in acute coryza, acute disorders of the various sinuses, frontal, maxillary, etc., atrophic and hypertrophic rhinitis, acute, chronic, and hypertrophic tonsillitis. The reports, however, seem contradictory, though preponderating opinions favor the method.

The results observed by the writer in Bier's clinic should encourage extensive trials of the technique by ophthalmologists, otologists, and practitioners generally. A number of cases of acute mastoiditis favorably influenced by this treatment. The results were fully as good, if not better, than from extensive surgical intervention. The affection heals without necrosis of the bone, the same as in osteomyelitis of the long bones treated with the congestive hyperemia in the same way. One

patient with suppurative meningitis was also treated; the pain was arrested at once, followed by the rapid retrogression of the objective symptoms. In one case of acute dacryocystitis this treatment alone proved promptly effectual; in a second case an incision was made into the tear sac. Keppler (Münch. med. Woch., Bd. lli, Nu. 47, 1905).

The writer has treated 36 patients with diphtheria, 12 with ordinary sore throat, and 7 with erysipelas by strapping a rubber band around the neck. Unmistakable benefit was derived in every case. In cases of erysipelas the process seemed to be arrested by the rubber band around the neck, and the patients could be dismissed in from three to five days. H. Hochhaus (Therap. der Gegenwart, Oct., 1905).

The writer applied Bier's constricting band to his own neck to study the effect on his eyes. The increased blood-pressure in the veins of the head and consequently of the eyes which he experienced, he believes, might possibly be dangerous for elderly persons, and in his therapeutic application of the measures he excluded all patients over the age of 40. The improvement in 5 cases of parenchymatous keratitis was so striking that he is convinced that this treatment has a future in this affection. The band was applied for six or twelve hours a day for two or four weeks. No favorable results were noticed in eczematous, phlyctenular, and catarrhal ulcers of the cornea nor in cases of old opacity, but serpiginous ulcers of the cornea yielded more readily to treatment when the passive congestion was added to the usual measures. No inconveniences were observed in any case. Renner (Jour. Amer. Med. Assoc., from Münch. med. Woch., Bd. liii, Nu. 2, 1906).

Personal observations and experiments that the Bier method is worthy of trial in numerous inflammatory diseases, phlegmon, furuncle, etc.,

dacryocystitis, **blepharitis**, the various forms of **conjunctivitis**, especially **phlyctenular**, and **trachoma**. Of diseases of the **cornea** it seems especially applicable in **ulcers** of whatever origin, perhaps also for the clearing of **pannus**, and in **interstitial keratitis**, in which condition the vascular formation would be furthered, a circumstance supposed to precede recovery. The influence upon the ciliary system of vessels and the increased secretion into the anterior chamber raise the hope that it may be of use in deeper inflammations, like **iritis** and **cyclitis**. Hesse (Centralbl. f. prak. Augenheilk., June, 1906).

The greatest number of opinions on the method are, so far, from foreign sources, and there has not been sufficient work done in this country to justify an estimate of its value. Several cases of mastoid reported cured were palpably ordinary **acute purulent otitis**, with evidence of mastoid tenderness, not uncommon in children. The treatment is effective only in acute or subacute cases, and requires skill and properly selected cases. F. W. Miller (So. Calif. Pract., April, 1908).

Since the writer has instituted the suction douche treatment for **mastoiditis**, but 2 cases out of 12 have come to operation. In both of these cases after all tenderness, pain, and fever had subsided, and the patient had been discharged from the hospital, home treatment was neglected and in two or three weeks they came back with a violent return of the symptoms. In both cases, at operation, the mastoid cells were found infiltrated with pus and the sinus extensively covered with granulations. Both cases made a perfect recovery, which was assisted by dry cupping at each dressing.

By irrigating in the presence of a partial vacuum we increase all the desirable actions of the irrigating fluid and annul or diminish the objectionable ones. One notable result is the lack of the soggy, waterlogged

appearance so common after the ordinary syringing. E. P. Fowler (Amer. Jour. of Surg., Nov., 1908).

Bier's method is of signal value in otorhinolaryngology. Its analgesic power renders it extremely useful in **tuberculous laryngitis**, and also in **tonsillitis** and **acute coryza**, the duration of which two disorders it materially shortens. **Aural furunculosis** is rendered much less painful. The elastic bandages were preferable to suction glasses. Its beneficial influence is less marked in **acute sinusitis**, **otitis**, and **mastoiditis**. It does not prevent puncture, paracentesis, or trephining. Its **postoperative use** is nevertheless helpful in the treatment of the incision. Gandier (L'Echo méd. du Nord, July 5, 1908).

Gynecology, Obstetrics, Urology, and Proctology.—The treatment by hyperemia has been advocated in *gynecology*, for the treatment of **chronic para- and perimetritis**, **parametritis posterior**, and **dysmenorrhea**; in *obstetrics*, for that of **puerperal arthritis**, **puerperal mastitis**, and **deficient lactation**; in *genitourinary surgery*, for that of **acute gonorrhea** and its complications, **prostatitis**, **epididymitis**, **cavernitis**, **impotence**, **gonorrheal rheumatism**, and **genital tuberculosis** of the same organs. In *proctology* it has been found useful in **anal fissure**, **hemorrhoids**, and in **anal tuberculous ulceration**.

Glass speculum for this purpose, constructed by the writer, with which is connected a rubber tubing which can be adjusted to a syringe or air pump to secure the necessary vacuum. In cases of **endometritis** the secretion is not only drawn from the uterus—more abundantly at first than later—but the hyperemia evoked aids in restoring the endometrium to its normal condition. The writer also observed the disappearance of inflammatory bands in the posterior fornix. He also has had some success in the use of Bier's apparatus for dispelling a **mastitis** and for bringing about a more bountiful **milk supply** after labor. In gynecological work the instrument is used

on alternate days for about thirty minutes. Eversmann (Zentralbl. f. Gynäk., Dec. 2, 1905).

In a case of **amenorrhea** of two years' duration the writer succeeded in re-establishing menstruation by five applications of the suction speculum for five minutes at a time in the course of five days. A number of other patients were not benefited. The best results were obtained in **chronic metritis**. In one case an attempt to use the speculum before inducing abortion brought on an unusually severe hemorrhage. Bauer (Wiener klin. Woch., Bd. xviii, Nu. 47, 1905).

The writer has treated 60 patients with **buboes** by application of a cupping glass to induce suction hyperemia, and reports good results. He gives an illustration of the large cupping bell he uses; it fits over the region and can easily be applied by the patient himself. It is applied for twenty minutes every two hours, with or without incision. The pain of **gonorrheal joint affections** was always promptly arrested by constriction hyperemia, combined with superheated air. Several cases are described of **genital tuberculosis** in young men in which remarkable benefit was obtained with the cupping bell. In 2 of the cases no other measures except a mutilating operation could have been considered. He believes that artificially induced hyperemia, applied in time, will render the treatment of genital tuberculosis much more conservative and promising than has been the case hitherto. Small foci in the prostate, and perhaps also the seminal vesicles, are favorably influenced and heal under suction applied to the testicles. The method is also of service in hastening the healing of fistulous passages. Frank (Jour. Amer. Med. Assoc., from Med. Klinik, May 24, 1908).

He applied the method in 25 cases of extremely painful **fissure of the anus**, 17 of **hemorrhoids**, and 6 of **tuberculous ulcerations** in or around

the **anus**. In the cases of **fissure** the relief from the pain was marked. Defecation ceased to be painful after only one or two applications of the suction apparatus. In most cases the application is followed by complete cure in the course of a week or two without the necessity for other intervention. The first application of the suction glass to hemorrhoids causes the nodules to swell and feel as if they had burst, but the relief from the pain is soon apparent; the nodules gradually subside completely, and the tendency to hemorrhage becomes spontaneously arrested in two or three days. He found the effect equally good in tuberculous anal ulcerations. Ogata (Zentralbl. f. Chir.; Diet. and Hyg. Gaz., July, 1908).

The writer precedes the application of the suction by scarification or a small incision. The method applied at the date of the menses has proved useful in the disturbances from the natural or induced menopause. He also applied the method with prompt success in a case of **puerperal infection**. After aspiration of large amounts of purulent secretion from the uterus, the fever subsided. He applies the suction for only ten minutes, but repeats it daily. His experience confirms the advantages of suction treatment of **mastitis**, **stitchhole abscess**, etc. Seeligman (Clinical Jour., Dec. 9, 1908).

The hot-air method is beneficial in **chronic inflamed adnexa**, **pelvic exudates**, **chronic parametritis** and **perimetritis**, **contracted painful scars**, and **fixed malpositions of the uterus** and **adnexa** when **resulting from inflammatory processes**. It is contraindicated when there is fever, in pregnancy, in hemorrhage not of ovarian origin, in menstruation and hemorrhagic endometritis, and in advanced pulmonary and cardiac diseases. A. Stein (Jour. Amer. Med. Assoc., Jan. 23, 1909).

The practical results obtained with the hyperemic method of treatment have proved beyond a doubt the ab-

solite correctness of the theories advanced by Bier. What must be our sole aim in the treatment of **impotence** is to retard the return of the blood from the organ, in this way increasing the quantity of blood normally contained therein; but in no way interfering with the influx of blood from the dorsal artery and the artery of the corpus cavernosum. Properly used, this method of treatment is in the writer's judgment absolutely correct, there being no pain, no cyanosis, and no inconvenience. In place of this there is a noticeable hyperemia of the organ, followed by a normal erection. S. T. Yount (Amer. Jour. Physiol. Therap., Sept., 1910).

In inflammation of the urinary passages with infiltration nothing loosens up the tissues and promotes absorption so effectually as the application of local heat. Patients bear without discomfort a temperature of 55° C. (131° F.) in the urethra, and the catheter can be left in place at this temperature for twenty-five or thirty minutes. The relief of pain is marked, and under all circumstances a warm catheter can be introduced much easier than one at ordinary temperature. Some patients otherwise requiring local anesthesia before the catheter can be introduced readily bear the introduction of a catheter heated to 30° or 40° C. (86° to 104° F.), and the dilatation can be carried much farther with heated catheters. He was one of the first to recognize the advantages of Bier's hyperemic treatment for urological practice, and five years' experience has only confirmed its importance. Frank (Deut. med. Woch., Nov. 6, 1913).

Dermatology.—In diseases of the skin its use has been found helpful in **acute eczema, acne, sycosis, psoriasis, mycosis of the nail, alopecia areata, and lupus.**

Practically all **chronic forms of skin diseases** are benefited by the hyperemic treatment before applying local remedies. The action of oint-

ments and lotions is considerably facilitated if a local congestion of the part is produced before they are applied. The most satisfactory results have been obtained in **psoriasis**, especially in some very old standing cases in which the lesions were very chronic and localized.

Some cases of **lupus vulgaris** have shown rapid improvement, the method giving earlier and much more satisfactory results than the X-rays had done. **Acne**, both diffuse and local, reacted well, but required a considerably greater amount of congestion and more frequently repeated treatments.

The immediate result of the local treatment is to produce a venous congestion of the skin, which increases the action of the sudoriferous glands, and gives rise to a varying degree of perspiration. This varies with the nature of the lesion and the degree of hyperemia produced.

In **eczema** and **seborrheas** a profuse perspiration is quickly produced, and after a few minutes the whole part is bathed in sweat. In other cases the ordinary sweat is replaced by a serous exudation. In some instances of **non-ulcerated lupus**, which as a class perspire very freely under the treatment, a blood-stained serum exuded after a short time, and for this reason the cases require to be very carefully treated and only for very short periods at a time, one minute or so being usually sufficient. Sibley (Amer. Jour. of Dermat., May, 1911).

So imposing an array of diseases in which a single line of treatment is indicated would seem to brand Bier's method as a universal panacea. But we must not lose sight of the fact that it is efficient in so many, because, as is the case with vaccine therapy and organotherapy, Bier's methods brings into play Nature's own resources against disease, a fact which in itself bespeaks a widespread application.

Concomitant Medical Treatment.—The benefit accruing from Bier's methods being admittedly due to the bactericidal and antitoxic functions the blood contains,

Sajours urged in 1908 that, inasmuch as thyroid gland, iodine, or the iodides, or, again, mercurials in small doses, enhanced the activity of these defensive functions, they should be used simultaneously. This view has been sanctioned by practical experience, especially in all conditions in which suppuration was threatened.

The writer indorses Bier's recent statement in regard to the great advantage of giving internally from 1 to 8 Gm. (15 grains to 2 drams) of sodium iodide a day to supplement the local hyperemia. This wards off development of cold abscesses. E. Joseph (*Therapie der Gegenwart*, June, 1913). S.

HYPERESTHETIC RHINITIS.

—**SYNONYMS.**—Hay fever; periodic paroxysmal vasomotor coryza; hay asthma; summer catarrh; autumnal catarrh; spasmodic coryza; idiosyncratic coryza; paroxysmal coryza; ragweed fever; nasal hydrorrhea; June cold; rose cold; peach cold; horse cold; cat cold; dust cold, etc.

DEFINITION.—A form of severe coryza, sometimes accompanied by asthma, characterized by periodical recurrences at more or less fixed intervals.

SYMPTOMS.—In some cases there appear, one or two weeks before the access, a mild coryza, heaviness about the brow, general malaise, chilly sensations, itching at the roof of the mouth, and eyes; but these manifestations do not always present themselves, the attack of hay fever beginning suddenly at precise dates—August 10th for hay fever; May 10th for "rose cold"—in the majority of cases. The disease occurs twice in the year in some individuals, but the great majority only suffer from one attack a year. "Rose cold" is somewhat shorter in duration than hay fever, which usually lasts about six

weeks. Subjects of the disease can usually point to the exact day, and sometimes the hour, of the expected attack.

The access usually begins with a sensation of itching in the nostrils, which soon becomes very intense, and causes violent and prolonged sneezing. A pricking, burning sensation in the inner canthi, followed by profuse lachrymation, may accompany this symptom, or constitute the first evidence of the attack. Very soon the nose becomes occluded through intumescence of its lining membrane, and respiration through it is practically impossible. A watery discharge appears, which soon becomes very profuse, and its strongly alkaline character causes it to irritate the nostrils and the upper lip, sufficiently sometimes to give rise to painful excoriations. Violent sneezing may begin at once, or occur when the watery discharge begins to trickle down along the intranasal walls, and the patient makes futile efforts, by immoderate use of the handkerchief, to clear the nose of the cause of obstruction and irritation. Chilly sensations, frontal headache, tinnitus aurium, loss of smell and taste, violent itching at the roof of the mouth, pain over the bridge of the nose, facial pruritus, and general symptoms, such as slight pyrexia, urticaria, disordered stomach, and flatulence, are among the possible accompaniments of this stage.

As the affection progresses, the nasal secretion assumes more of a mucoid character, becoming at times mucopurulent. The conjunctiva may become greatly inflamed, and photophobia and marked chemosis follow, rendering, in some cases, a prolonged

stay in a dark room necessary. Asthma may occur as a complication of the affection, or as its only symptom. It may present itself any time during the course of the disease; it manifests itself suddenly as soon as the irritating agent is inhaled. In the majority of cases, however, it begins a few days after the primary nasal symptoms have shown themselves, and as soon as these become marked.

ETIOLOGY AND PATHOGENESIS.—Many years ago (1885) I called attention to the importance of general adynamia as a predisposing cause of this disease, after a study of 40 cases. Of these patients 35 per cent. had near relatives who presented a clear history of hay fever or rose cold, and 42 per cent. had asthmatic near relatives. The early history of these cases also pointed to considerable vulnerability to the diseases of childhood: 40 per cent. had had six of these diseases; 60 per cent. had had five. These disorders were whooping-cough, measles, mumps, chicken-pox, scarlet fever, and diphtheria or croup. A comparison of these 40 cases with forty subjects, taken haphazardly, who had never suffered from either hay fever or asthma, emphasizes this vulnerability of future hay-fever sufferers; while the aggregate of the diseases of childhood in the latter was 189, in the normal subjects it was 92, less than one-half.

A number of authors have independently urged a similar underlying cause: Joal (1895) and Cartaz, for example. Fink holds also that "the patient is always neurasthenic." Guéneau de Mussy, as far back as 1868, attributed the disease to "arthri-

tism," a synonym for our "gouty diathesis." Leflaive, Bishop, Grube, and others have also urged this view—which obviously harmonizes with my own, the gouty diathesis being, to a certain extent, a manifestation of adynamia. Interpreted with the functions of the ductless glands as factors of the problem, this becomes all the more evident, in that I attribute primarily this diathesis to inadequate breaking down of wastes by their secretions, including the leucocytic trypsin and the adrenal ferment, the end-result being the conversion of food nucleins into harmless, eliminable end-products. Inability to carry on this process may be actual, *i.e.*, due to hypoactivity of either of the organs of the adrenal system, or passive, these organs, though normal, being unable to provoke the formation of sufficient autoantitoxin to insure catabolism of the excess of wastes with which the lymph and blood are burdened when overeating is indulged in. In either case the blood contains more or less toxic wastes of the purin type, which incite the various disorders usually ascribed to the gouty diathesis.

We cannot, however, include hay fever among the disorders incited by the toxic wastes in the blood of gouty subjects, since the vast majority of gouty subjects do not have hay fever. The immediate cessation of the attack when the patient goes to sea or to localities in which the disorder does not prevail also militates against this. Were the gouty or any other diathesis its exciting cause, hay fever would obviously occur regardless of locality. It is plain that we can only consider this feature of the disease as a *predisposing cause*. In other words,

while we cannot say that hay fever is caused by gout or the so-called "uric acid diathesis," adynamia, neurasthenia, etc., we can say that such a debilitated state of the organism prepares it for the development of that disease.

Two prominent features of the disease, which, under these conditions, initiate the disease, have long been recognized: its identity as a neurosis (Beard, 1876) and the fact that, during a paroxysm at least, the nasal mucous membrane is oversensitive (Roe, 1883). The latter factor is so marked that many years ago I suggested, in lieu of the faulty term "hay fever" (faulty in the sense that the disease may be provoked by many irritants other than new hay), that of "hyperesthetic rhinitis," which has been accepted by many classic writers. But in this hyperesthesia of the Schneiderian membrane we must only see the external manifestation of a similar condition of deeper nervous structures, viz., of the general nerve center to which the sensory impulses are transmitted. It is this central disorder which the gouty diathesis or the general adynamia (inherited or acquired through disease we have seen) awakens, the center involved being rendered hypersensitive by the imperfectly catabolized, and therefore toxic, waste products which are ever present in the blood in this class of cases.

The sensitive center—a nucleus of the fifth pair—appears to be, from my viewpoint, located in the pituitary body. Cyon has previously observed that after removal of this organ the nasal mucous membrane at once lost its sensitiveness, and that the most active stimulants, including ammonia,

failed to elicit the least reaction: sneezing, lachrymation, etc. It would appear then that the nasal mucous membrane is oversensitive, because the center which receives its sensory impulses—that of the fifth pair—is itself oversensitive, and the excessive sneezing, lachrymation, etc.—that constitute the symptom-complex of the disease (all complications, asthma, photophobia, etc., being the result of involvement of neighboring nuclei)—are but exaggerated expressions of physiological functions.

The local condition being one of complete vasodilation, it may be due to an easily disturbed balance between the constrictors and the dilators, or a weakness in the vascular tone. Why the imbalance or weakness, would be hard to say, unless we accept some of Sajous's theories in his physiology of the ductless glands, and say it is due to a natural deficiency in the production of those elements which promote stability in the vascular system and protect against infections, the adrenal and thyroid secretions. W. H. Phillips (*Cleveland Med. and Surg. Reporter*, Sept., 1908).

Hay fever is an expression of local hypersensitiveness, established spontaneously and never by immunologic process. The active pollen substances are not toxins. The antibody-like substances of human sensitization are not demonstrable in the blood of sensitive persons by any of the immunity reactions. They are present in the cells of the sensitive tissues. They cannot be increased artificially by the usual process of immunization. The mechanism of relief from vaccine therapy is like that of desensitization in experimental anaphylaxis. Flood and Coca (*Jour. of Immunology*, Feb., 1917).

The next question in point is the periodicity of the disease. As is well

known, it appears—in typical cases—at stated seasons, oftentimes recurring each year on, or near, the same day. This serves to prove the correctness of the view (Elias Marsh, 1877) that certain pollens are the exciting factors of the paroxysms, and that when these pollens, the principal of which is that of ragweed, appear in the air the disease is awakened. The fact that these identical pollens—when preserved in their normal state—may provoke an attack at any time of the year, at sea, or in countries where the patient is otherwise immune, emphasizes the solidity of Marsh's view.

Dunbar has succeeded in extracting from the pollen of certain grasses (maize, wheat, rye, etc.) a toxin which, when instilled into the eyes or nostrils of persons predisposed to hay fever, produces in these parts the characteristic subjective and objective symptoms of the disease. The toxin, when injected into the eyes or nostrils of persons not predisposed, produces, in the great majority of cases, no symptoms whatever. But it certainly appeared as if there were instances of transition in which, although the persons experimented upon never suffered from typical hay fever, they were yet more susceptible to the influence of the toxin than the ordinary run of people. The effects of the toxin in persons suffering from hay fever are as variable in intensity as are the attacks of the affection itself, both with regard to the local and the constitutional symptoms.

The especial sensitiveness of the nasal mucosa to certain pollens has been attributed to specific physical and chemical properties, but this academic question is still *sub judice*.

Two theories concerning the

manner of action of pollen grains in hay fever have been vouchsafed: the first, that they act as soluble toxins; the second, that they act as foreign proteins, inducing anaphylaxis in sensitized individuals. Neither theory is completely supported either by the known facts or by the experimental evidence thus far brought forth. Further investigation is necessary. Likewise anaphylaxis itself needs further study (Theobald Smith). While the symptoms of hay fever which at any time may be brought on certain subjects by riding behind a horse may be ascribed to the dust, pollen, etc., the animal's fur may contain, that caused by cats, lobsters, and other agencies defeats the view that anaphylaxis has anything to do with the process and sustains the view that we are dealing purely with a neurosis in which hyperesthesia of the nasal mucosa is the dominating factor.

Hay fever is most frequently met with among brain-workers, professional men, clergymen, lawyers, merchants, etc. It may occur at any age, and seems to prevail with more frequency in men than women. It is more common in the Northern than in the Southern States, and in low, flat countries, as a rule, than in the mountains; but the White Mountains, the Catskills, and Adirondacks, formerly thought to be free of cases, are no longer so to a certain proportion of sufferers.

TREATMENT.—In certain cases what might be termed a pseudoform of hyperesthetic rhinitis is provoked by the presence in the nose or nasopharynx of polypi, exostoses, turbinal hypertrophies, etc. (Daly, 1881). These projecting morbid tissues,

mainly by irritating the sensory terminals of the surface apposed to them, render hyperesthetic not only this surface, but also the center to which the sensory impulses are transmitted, that of the fifth pair. Such cases are often not only sensitive to many pollens, but also to many commonplace irritants. They are readily cured by properly executed **removal of the morbid growths**, but in such a way that no adhesions or synechiæ are left between the apposed surfaces. **Cauterization of the hyperesthetic areas** caused by them, by the local application of **glacial acetic acid**, **chromic acid**, or **galvanocautery**, tends further to insure recovery.

Irrespective of any organic disorders of the nasal cavities, the disease may be arrested—at least for a time — by similar applications to hyperesthetic areas, the latter being detected by sweeping a flat probe gently over the mucosa, both of the septum and of the surfaces of the turbinals and of the floor of the cavities, the itching caused by this procedure being greatly increased when the oversensitive areas are encountered.

Such results are not always obtained, however; nor is the disease checked permanently in any but a very small proportion of cases. It has been suggested that beneficial effects are obtained from local treatment only through suggestion. But such a view is erroneous, for in one of my cases applications of cautery to one nostril only caused it to remain free during all succeeding attacks.

To understand the *modus operandi* of remedies administered internally, the manner in which the morbid symptoms are awakened by the

atmospheric irritants—as interpreted from my standpoint—is necessary. When the specific irritants appear in the air the violent sensory impulses transmitted to the trigeminal center provoke reflex dilatation of the arterioles which supply blood to the mucosa of the nose, sinuses, conjunctiva, etc., and all these structures become intensely congested—the exciting cause of the distressing symptoms. Beneficial effects can be obtained, therefore, by remedies which either locally, or by acting on the sympathetic center, provoke constriction of the dilated arterioles.

As to *local remedies*, a 5 to 10 per cent. solution of **cocaine** sprayed into the nostrils is very effective, but I only mention this remedy to condemn it, owing to the danger of producing the cocaine habit in the patient. A weak—1:5000—solution of **adrenalin chloride**, prepared with normal salt solution, also tends to contract the arterioles by inciting active metabolism in their muscular coat. A 1:1000 **ointment of adrenalin** is available in tubes provided with a tip, which enables the patient to apply adrenalin directly to the swollen tissues. It affords comfort by depleting the engorged mucosa. The effect however, is not lasting and is followed by greater dilatation.

We have in the aqueous extract of **suprarenal glands** a powerful local vasoconstrictor agent, and a contractor of erectile tissue, which it is safe to use in very considerable amounts without any dangerous or deleterious effects locally, or to the general constitution of the individual. In acute congestions it has its widest application and greatest opportunity for good, but in certain chronic conditions of the hay-fever type where redundant tissue seems prone to de-

velop it can be relied upon as one of the most helpful adjuvants which we have at command. H. L. Swain (Med. Record, June 4, 1898).

Hay fever successfully treated by **suprarenal substance**, all other measures being abandoned. Tabloids, representing 5 grains (0.3 Gm.) of suprarenal substance, were allowed to dissolve in the mouth every second, third, or fourth hour, according to the effects. If coryza or sneezing had begun, it would cease within fifteen minutes after taking a tabloid. S. Solis-Cohen (Phila. Med. Jour., Aug. 13, 1898).

Snuffing of a 1 per cent. solution of **trichloracetic acid** as a cure for hay fever used in more than 30 cases with the very best results. Improvement and cure follow in two to eight days. H. Krause (Therap. Monats., May, 1901).

From **adrenalin** used locally the writer has seen but little good. Its action, whether from poor absorption or because of the excessive vasomotor paralysis, is weak and short, and is followed, if anything, by an even greater dilatation. Injected sub-mucously, 1:5000 or 1:10,000, it acts better and its effect is more prolonged, and for temporary relief in asthma is to be recommended. W. H. Phillips (Cleveland Med. and Surg. Reporter, Sept., 1908).

The writer gave **sodium bicarbonate** in dram (4 Gm.) doses 3 times a day to 50 hay fever patients. Ninety per cent. were markedly benefited, 70 per cent. obtaining complete relief after a few days' treatment. In 3 cases a nasal spray of sodium bicarbonate solution was superadded. Kellogg (N. Y. Med. Jour., Aug. 21, 1915).

Six hay fever patients were treated with **pituitary** (1 c.c.—16 minims) and **adrenalin** (0.5 c.c.—8 minims) injections. All had cardiac dilatation with digestive disorders and indicanuria. All showed reduction in the size of the heart, and the hay fever attacks did not return, or were lessened in intensity. Cardiac disturbances, with

lack of vasomotor tonus and low circulation, may favor the manifestations of pollen irritation. Zueblin (Med. Record, July 7, 1917).

The patency of the cavities may be sustained by spraying over the constricted mucosa a 5-grain-to-the-ounce (0.3 Gm. to 30 c.c.) solution of **menthol** in liquid petrolatum, or any other light oil. A saturated solution of **quinine** used as a **spray**, followed by the application of an **ointment** composed of 30 grains (2 Gm.) of **quinine** and 1 ounce of vaselin, are recommended by Fulton. **Insufflations of orthoform** have also been extolled by Lichtwitz. All these measures should only be regarded as palliatives, however; they serve to relieve stenosis, allay irritability, and control excessive secretion.

Intense itching of the eyelids, especially near the lachrymal caruncle, sometimes causes severe suffering. This is markedly allayed by **flooding the eyes with hydrant water**, using for the purpose the top of a flower sprinkler attached to a rubber tube connected with the spigot. **Cold compresses**, *i.e.*, cloths wrung out of ice water, applied to the sufferer's forehead and face, and renewed as soon as they become "the least bit" warm, afford marked relief, according to Wolner, when kept up constantly for about three hours, and off and on for about six hours. Photophobia is another annoying symptom—also due to dilatation of the arterioles of the fundus and congestion—a result also of the central supersensitiveness. **Blue or smoked glasses** tend materially to alleviate this symptom.

The *internal remedies* indicated in this disease can be divided into two

Dunbar's pollantin has been lauded by some clinicians. The production of an active immunity by means of a **vaccine** prepared from various grasses has also given encouraging results.

W. C. Williams (Milit. Surg., Feb., 1920), found that out of 27 cases of hay fever diagnosed, 81.4 per cent. were due to a sensitiveness to the pollen of the ragweed, while 18.5 per cent. were due to a similar sensitiveness to golden rod pollen. The diagnostic cutaneous reaction offers a simple and clear cut method of determining sensitiveness to pollen proteins. Extract of the ragweed pollen proved useless, but **golden rod pollen extracts** in 3 cases seemed beneficial in 2 cases and markedly so in 1.

When the patient can be studied before the hay fever season, a survey of his habitual surroundings and skin tests should be made with pollens that might be connected with the anaphylactic phenomena. If the attack has already started, a vaccine of the pollens most likely responsible should be begun at once. Authors report 63 cases treated with **pollen vaccines**. Of 18 complicated with asthma, 11 were entirely relieved. Of the remaining 44, 17 were entirely relieved, 18 considerably relieved, 4 slightly relieved, 2 not relieved, and 3 not reported. The vaccines used were, in the spring, a mixture of pollens from red-top timothy, rye, and orchard grass, and, in the fall, ragweed alone. The possibility of a concurrent bacterial infection should always be taken into account. Hitchens and Brown (Jour. of Lab. and Clin. Med., Apr., 1916).

More or less successful results are being attained regardless of how the **pollen toxin** is prepared. It deteriorates so rapidly that it is quite useless within 48 hours after the change begins, and advises the use of fresh toxin every 8 to 12 days. Howe (L. I. Med. Jour., May, 1916).

Hay-fever pollens extracted with 66% per cent. glycerol and 33 $\frac{1}{3}$ per cent. saturated sodium chloride solution yields a very stable and potent, as well as sterile, antigen. Clock (Jour. of Infect. Dis., Oct., 1917).

Injections of **pollen toxin**, according to the procedure of Noon and Freeman, can be intensified by the internal exhibition of **calcium chloride**. The initial dose should be estimated after the cutaneous and ocular reactions have been obtained, and the doses injected should be slowly but progressively increased. K. Eskuchen (Deut. med. Woch., Feb. 18, 1919).

Results of desensitization treatment based on 330 cases of true hay fever, 123 of which had received the treatment for 2 or more years. (1) No improvement, 7 cases. (2) Improvement as compared with previous years, but showing, nevertheless, troublesome symptoms for a short time, 46 cases. These patients were not materially better than most cases treated in previous years by cauterization and general hygienic measures. (3) Very definite improvement, apparently beyond criticism, 59 cases. These include patients with a previous history of severe attacks who, under treatment, exhibited only slight symptoms, and patients with a previous history of hay asthma, who went through 2 or more summers without asthmatic symptoms. (4) Patients who showed no hay fever for 2 or more years in spite of full exposure to pollen, 5. J. L. Goodale (Boston Med. and Surg. Jour., Aug. 29, 1918).

In 91 cases of fall (ragweed) hay fever, the following results from **specific treatment** were obtained: Nearly 9 per cent. of the patients were entirely freed from symptoms; 62 per cent. considerably relieved; 28 per cent. obtained no relief at all,—all determined by personal communications 4 to 6 weeks after the ragweed season, 19 patients failing to reply. The best results were apparently obtained with a moderate amount of specific treatment. Sys-

temic reactions occur after 2 per cent. of individual injections, and are not always due to overdosage. The disease probably depends less upon anaphylaxis than association with drug idiosyncrasy. Rackemann (Boston Med. and Surg. Jour., Mar. 18, 1920).

It is urged that the administration of pollens should not be made in acute attacks of hay fever, as the patient at that time is already saturated with toxins and upon inoculating him with pollens he often becomes worse. The use of pollens should begin about 3 months before the attack and cease 6 weeks before the attack is due. During the attack the writer uses **bacterial vaccines** in small doses to stimulate an immunity against rhinitis, which is concomitant with hay fever. In asthma it is important to ascertain the presence of underlying factors, such as nasal obstruction, cardiac and renal disease, and focal infection, and not to depend exclusively upon the proteid tests and desensitization. M. S. Ersner (Penna. Med. Jour., Apr., 1921).

As to the remedies which tend to counteract the gouty diathesis, the only one which has served me faithfully is desiccated **thyroid**, which acts by enhancing, as do the iodides, the catabolism of toxic wastes. It may be given in 2-grain (0.13 Gm.) doses twice daily for three days, then once daily only. **Strychnine**, in $\frac{1}{50}$ -grain (0.001 Gm.) doses after meals, enhances the action of thyroid extract by stimulating the vasomotor center and increasing the oxygen intake. When the use of these agents is begun two or three weeks before the expected attack, its severity and duration are often reduced.

The writer at times administered the **catarrhal organism** (vaccine) combined with the **pollen vaccine**. In one-half the cases success was obtained. G. B. Webb (Boston Med. and Surg. Jour., Jan. 6, 1916).

When mucous membranes have become irritated, micro-organismal activity complicates the clinical picture of hay fever. **Autogenous vaccines** should then be used, often acting as well as pollen extracts. O. Berghausen (Lancet-Clinic, Apr. 1, 1916).

Climatic Treatment.—There are many persons who derive little or no relief from the ordinary methods of treatment. Such persons will do well if they seek temporary residence in an environment lacking in the various pollen which excite the paroxysms of hay fever, or, better, if they spend the hay-fever season in an ocean cruise. Certain rocky locations, bare of vegetation, have been sought and patronized by these sufferers. The length of one's stay should be until the first frost at home, when they can usually return with safety. The question of expense enters here, which many cannot afford.

Surgical Treatment.—Various operations have been suggested for the relief of hay fever, from the milder ones of **intra-neural injection**, and **removing spurs and other obstruction**, to those involving **nerve section or resection**, with an idea of permanently abolishing sensation in the vulnerable localities.

Method of **resection of the nasal nerves** in desperate cases of hay fever, based on the theory that the stimulant which induces the reflex manifestations observed in hay fever and in paroxysmal coryza is conveyed to the centers of the nasal nerve, which is thus the afferent path of the reflex. Resection of the nasal nerve on the right side was first performed, chloroform anesthesia being employed. The nerve was reached by an incision at the inner edge of the orbit, commencing

just above the inner canthus and extending upward and slightly outward for about $\frac{3}{8}$ inch. The cellular tissue having been cleared from the inner wall of the orbit by means of a blunt dissector and the nerve located at the anterior ethmoidal foramen, the latter was separated from the artery and divided close to the foramen, about $\frac{1}{4}$ inch of the nerve being removed. Horsehair sutures were inserted and the wound was dressed with gauze and collodion. The stitches were removed on the fourth day. Resection of the nerve on the left side was carried out four weeks later. Two months after operation the paroxysmal coryza, sneezing, and asthma had entirely disappeared, there was increased freedom of nasal respiration, and consequently the patient slept better. He had gained 7 pounds in weight and the general health was manifestly improved. Yonge (*Lancet*, June 13, 1908).

New method of treating hay fever surgically, viz., by **section of the nasal nerve** as it emerges from the anterior ethmoidal foramen at the inner third of the supraorbital margin. The operation is done under local anesthesia by **novocaine** and **suprarenin**. The writer now reports the ultimate results obtained with this method in 3 cases. In each instance complete relief was obtained. One of the patients, a soldier who had suffered from hay asthma for eight years, was enabled to take part in the annual maneuvers without inconvenience. A girl of 14 years in whom the use of morphine had been necessary during the attacks in former seasons was likewise cured by the operation. E. Bloss (*Deut. med. Woch.*, Dec. 8, 1910).

The operative treatment of hay fever by bilateral **resection of the anterior ethmoid nerve** is an intervention based on insufficient anatomical and physiological hypotheses. The therapeutic result is indefinite, because of the possibility of operative injury to the neighboring tissues.

In seeking the route of the centripetal irritation we must consider not only the N. nasociliaris, but also the Nn. palatini and nasalis post. of the second trigeminus and N. infra-orbitalis. The hay fever may also originate in the air passages or bronchial mucosa. Resection of the N. nasociliaris does not remove all reflex irritation; resection of the anterior ethmoidal foramen does not affect the nerve trunk, but merely one of its branches, namely, the N. ethmoidalis ant. The N. infratrochlearis is also unaffected. If improvement in the dyspnea took place after resection of the ethmoid nerve, the conclusion was that the condition was of reflex nasal origin. T. Albrecht (*Deut. med. Woch.*, July 27, 1911).

Intraneural Injections of Alcohol.

—It has been suggested that, intraneural injections having been used to produce local anesthesia for operative purposes, and also for the treatment of neuralgia, they might be employed in the treatment of hay fever. Stein, of Chicago, introduced this method in 1906. Following the suggestions of Schlosser, he has used alcohol, pure and diluted (50 to 75 per cent.), for the purpose, using only a few drops (10 to 15) in each injection, and injecting the nerves as near their central ends as safety and accessibility would allow, in most cases within the nose.

By **injecting the nasal nerve** at its point of entrance into the nose, we deprive both its internal and external filaments of their hypersensibility. If we are to afford immunity to all cases of this disorder, it will be necessary to inhibit the action of the entire nerve supply of the nose, which means anesthetizing both the anterior and posterior group of nerves. This is easily done by selecting the proper length and curve of hypodermic needle and intro-

ducing it into the neighborhood of these nerves as they enter the nose. In the case of the nasal nerve a needle $2\frac{1}{2}$ inches long is required, whose point is entered at the anterosuperior angle of the nasal cavity, against the inner surface of the nasal bone, and near its distal end. The posterior group of nerves is reached by a needle $3\frac{1}{4}$ inches long with a curve near its end of 45 degrees. This is entered in the neighborhood of the sphenopalatine foramen, which is located in the sphenothmoidal fossa, just above and to the outer side of the posterior end of the middle turbinal. Both nostrils are injected, requiring 4 injections, 2 for the anterior and 2 for the posterior groups. In some cases it may be necessary to inject only the anterior groups.

The injections are made painless by a preliminary application of a cocaine solution. No serious ill results have been encountered. The writer has found that the injections had to be repeated from one to four times, covering the season of attack. O. J. Stein (*Laryngoscope*, Sept., 1908).

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HYSTERIA.—Hysteria is an affection which occupies a peculiar though an independent position in our nosology. It is characterized by the facts that the symptoms are always of psychic origin, that they are always the result of suggestion received from within or without, that they are in their nature unreal and unsubstantial, that, though at times persistent, they come and go, are fugitive and shifting, disappear spontaneously or under persuasion, and finally that they always arise in individuals who are neuropathic and who are predisposed by their very makeup to the affection.

The war afforded an opportunity for studying hysteria in men such as never occurred before, and the lessons learned can be applied to the elucidation of many of the problems presented by hysteria in civil life. The writer defines hysteria as a condition in which symptoms are present which have been produced by suggestion and are curable by psychotherapy. He regards the so-called physical and mental stigmata of hysteria as merely artifacts, usually produced by suggestion on the part of the examiner. There is no narrowed field of vision unless it is suggested by the method of examination. By conducting a simple examination for the fields of vision in opposite ways on the 2 eyes of the same person 1 field can be made to show a progressive spiral narrowing while the other shows a progressive spiral widening. The same rôle of suggestion is equally important in the matter of the so-called hysterical anesthesia, no anesthesia being present unless definitely suggested. Abnormal suggestibility is clearly a predisposing factor, but hysteria may develop in perfectly normal persons under suggestion sufficiently prolonged and powerful. A. F. Hurst (*Lancet*, Nov. 1, 1919).

It is of the utmost importance to differentiate hysteria from the other functional nervous disorders. Under the influence of the school of Freud and of his followers, there has been a tendency of recent years to confound the various functional neuroses with each other. Nothing could be more unfortunate from the standpoint of practical medicine. Diagnosis and prognosis alike become impossible. It is absolutely essential that hysteria should be differentiated from the following conditions. In the first place, hysteria must be clearly distinguished from the neurosis of chronic fatigue, *i.e.*, neurasthenia. Hysteria is con-

stantly met with without the presence of a single fatigue symptom, just as it is constantly met with without a single organic lesion. Again, hysteria must be clearly distinguished from hypochondria. In the latter affection there is a characteristic symptom-group in which the patient is dominated by an all-convincing sense of illness, the cause of which he usually refers either to his digestive tract or to his sexual organs. Such patients, it need hardly be pointed out, never betray either the psychic, the sensory, or the motor stigmata of hysteria. Further, we must differentiate hysteria from psychasthenia, the neurasthenic-neuropathic symptom-group which the Freudian school has especially confounded with hysteria. The phobias, the indecisions, the aboulias, the irresistible impulses of neurasthenic-neuropathic mental disease have no place in the symptomatology of hysteria; nor, on the other hand, do we find in psychasthenia the anesthetics, the palsies, the painful sensory stigmata, the paroxysms of hysteria. There is absolutely no relation between the two conditions.

What, then, is hysteria? If we examine a case of hysteria, we are at once impressed by the fact that the symptoms presented are, as already stated, of a mental origin. Thus we discover in a patient an anesthesia. If we outline the area involved, we find that it bears no relation either to the distribution of the nerves or to the spinal segmentations. Quite commonly the loss of sensation involves the hand like a glove, or a foot and leg like a stocking. Such a loss is, of course, not in keeping with any fact of nervous anatomy. Finally,

such a sensory loss may shift in distribution, may come and go, may vary in intensity. The only possible inference is that such a symptom is of psychic origin. This conception of hysteria has now fortunately taken hold firmly of the modern medical mind.

The French have elaborately studied hysteria, and it is due to Charcot, his pupil Gilles de la Tourette, and his followers that we today have an adequate conception of the affection, but it is due to Babinski that the fact of the origin of the symptoms in suggestion has been especially emphasized. Indeed, Babinski points out that many of the symptoms elicited are largely due to the examinations made by the physicians. That there is much truth in this position will become apparent as we proceed. The neuropathy of hysteria is inherent, and is part and parcel of the makeup of the individual, and is present from the very hour of his birth. Such individuals present an abnormal, a pathologic, susceptibility to suggestion, so that symptoms are grafted upon the patient's mind with the greatest ease. Occurrences in themselves utterly trivial and without significance may be followed by palsies of limbs, hemiplegias, convulsive attacks, paroxysmal seizures, and what not. At times the incident which precedes the onset of symptoms consists merely of a fright, there being not the slightest physical trauma of any kind, and yet the most massive hysteric symptoms may supervene. That normal persons do not react in this way need hardly be stated.

The fact is that the hysteria really pre-exists and is simply brought to

the surface by the suggestion of the fright or shock.

To show the rôle of suggestion in the development of the symptoms in hysteria, the experience of Babinski in regard to hemianesthesia is well worth recalling. Babinski found that, in testing 100 consecutive cases of hysteria for hemianesthesia, he failed to elicit the symptom in a single case, inasmuch as he carefully avoided suggestion. Babinski maintains that the sensory losses of hysteria are always the outcome of inadvertently made suggestions. He claims, for instance, that the reason hysteric hemianesthesia predominates on the left side of the body is because the physician, being usually right-handed, has the brush or esthesiometer in his right hand and naturally tests the left side of the patient first, thus suggesting the very hemianesthesia he is trying to discover. It is quite obvious that such a procedure will not and can not elicit the symptom of hemianesthesia in a normal individual, *i.e.*, in a person who has not the hysteric constitution. The normal individual repels, the hysteric individual accepts, the suggestion. It is this inability to repel harmful and painful suggestions which constitutes hysteria. This is, of course, true whether the phenomena which arise in the patient consist of anesthetics, of palsies, visceral disturbances, or other symptoms. Sometimes suggestion results in imitation. One hysteric patient may excite similar symptoms in another or indeed in a group of persons. At first such an imitation may seem purposive or voluntary, but later it may seem involuntary and even subconscious. Hysteria is, then, in a sense, contagious. Numerous instances of

the contagiousness of hysteria, *e.g.*, between young girls in school, might be cited. One patient presents the symptoms of hysteria and subsequently the same or similar symptoms make their appearance in others who happen to be susceptible. Some years ago Raymond presented at the Neurological Society of Paris a young woman suffering from hysteric hemiplegia with contractures. The history of the case was that the patient and her husband, recently married, had spent their honeymoon at the seashore, and it so happened that in their daily walks they met an old man suffering from hemiplegia. No comment was made by the young woman, but some time after returning to her home she began to walk as did the old man, while her limbs also assumed the positions of fixation and contracture. Obviously such a result as this could only have occurred in a neuropathic individual, *i.e.*, in an individual in whom the hysteria had previously and potentially already existed.

In addition to the pathologic vulnerability to suggestion, the psychic makeup of the hysteric subject presents certain other features in keeping with this feebleness of resistance. Thus, just as impressions suggestive of various symptoms are followed by an undue reaction, so does the patient present an undue or pathologic reaction to emotional stimuli. That the hysteric patient laughs and cries more readily is a fact of common experience. Often, too, the actual emotion experienced is less keen or profound than the outward signs would suggest. Indeed, emotional instability and exaggerated emotional expression are symptoms of everyday

observation. Similarly the hysteric patient is more readily frightened than is the normal person, and the degree of fright and its outward manifestations may not only bear no relation to each other, but may be out of all proportion to the cause of the fright, which not infrequently is trivial; indeed, at times, practically non-existent.

SYMPTOMS.—The symptoms of hysteria may make their appearance in childhood, at puberty, during youth, and less frequently may be delayed until the third or fourth decade of life. However, the late appearance of hysteria is rare. Usually cases of late oncoming hysteria—if the history be carefully studied—reveal the undoubted presence of the hysteria at earlier periods of life. When once established, manifestations of hysteria may be observed at all ages, even in middle age and old age. The writer's experience, based upon many years of observation both in the hospital and in the community at large, justifies the belief that the symptoms of hysteria never make their appearance save in an individual in whom the hysteria has pre-existed. In other words, the exciting incident—if there be one—merely serves to bring the slumbering affection to the surface. Among the incidents other than suggestion which may lead to the manifestations of the symptoms of hysteria are, as already indicated, fright and emotional experiences.

Hysteria bears no relation to mental strain or overwork, nor does physical shock, unconnected with fright, play a rôle. For instance, accidents occurring during sleep do not elicit the manifestations of hysteria. Visceral affections, it need hardly be

added, are not a cause of hysteria, and this is true especially of pelvic disease. The name hysteria has its origin in the supposed relation between the uterus and the nervous phenomena, an idea which, though without any foundation, has persisted until relatively recent times. It is unnecessary to point out that hysteria is uninfluenced by pelvic operations, and finally that it occurs in the male as well as in the female sex.

While all of the symptoms are of mental origin, it will prove convenient to divide them into sensory, motor, visceral, and purely psychic disturbances.

Sensory Symptoms.—The disturbances of sensation may present themselves in the form of loss or diminution, of excess, or of a change in quality, *i.e.*, there may be present an anesthesia or hypesthesia, a hyperesthesia, or a paresthesia. Being psychic in origin, these sensory phenomena are characterized by the fact that they bear no relation to nerve distribution or to spinal segmentation. Thus, a patient may present an anesthesia of a hand, investing the latter like a glove; such an anesthesia is spoken of as a glove-like anesthesia, and obviously bears no relation to the facts of nervous anatomy. A similar loss of sensation may be present in the foot and leg, and is then spoken of as a stocking-like anesthesia. Again, it may involve a small segment of a limb. Thus, it may extend from the wrist to the elbow, the parts above and below being entirely normal in their responses. In such an instance we speak of a segmental anesthesia. It may, on the other hand, be limited to an irregular patch on the trunk, limbs, or face. Such an

instance is spoken of as geometric anesthesia or islet-like anesthesia. Here again it is, of course, apparent that we have to do with an anesthesia that is independent of spinal segmentation or nerve distribution. It must, therefore, be psychic in origin, *i.e.*, we must look for an explanation to some disturbance of the cortex.

Not infrequently a sensory loss involves the entire half of the body, thus constituting a hemianesthesia. More rarely it involves the entire body or almost the entire body. Such a hemianesthesia is apt to be defined by a sharp line in the middle of the body, but, as neither such a sharply defined hemianesthesia or a so-called total anesthesia can be referred to definite anatomic lesions, we are again forced to refer them to a psychic origin. The sensory losses of hysteria usually involve all the qualities of sensation; for example, touch, pain, and temperature, but in certain rare instances a dissociated or partial sensory loss may occur, *i.e.*, the patient may claim that he feels the touch, but can no longer recognize heat or cold or pain. The most common finding is that of a partial sensory loss to all forms, *i.e.*, a lowering of sensation to heat, cold, pain, and the tactile sense. Such a sensory loss is termed a hypesthesia. Instead of a sensory loss as just stated, there may be an exaggerated sensory response, *i.e.*, a tenderness, a hyperesthesia, may be present. Such a hyperesthesia may be widely diffused, for instance, over the back or over the abdomen. More frequently, however, it makes its appearance in small spots, isolated and rounded or oval in shape. If such an area be touched, especially when the patient has full knowledge

that an examination is being made, the patient's reaction may be excessive, *i.e.*, he will react as though the area touched were excessively sensitive or painful. This hyperesthesia, whether diffused or occurring in small areas, is characterized by one remarkable fact, and that is that if the finger of the operator comes lightly in contact with the supposedly sensitive area the patient, as already intimated, reacts excessively; acts as though he were suffering acutely. If, however, the finger or the hand is allowed to rest upon the supposedly painful area and deep pressure is gradually made, all painful response ceases, *i.e.*, the pain complained of is referred by the patient to the *surface* only. He does not refer it to the deeper tissues. Further, he becomes entirely unconscious of it when his attention is fixed upon some other portion of his body. If, for instance, a painful area be found to exist over the spine and the hand allowed to rest on this area, at the same time that the patient's attention is skillfully drawn to the front of the chest, to the abdomen or elsewhere; or if the physician, his hand still resting upon the tender area over the spine, proceeds to auscultate the heart and in his conversation directs the attention of the patient to the heart's action, no response is made by the patient whether the supposedly painful area is pressed upon or not. In other words, the pain and tenderness of hysteria, like the other symptoms, present an appearance of being alike unreal and unessential.

Areas of this so-called painful hyperesthesia may make their appearance upon any portion of the trunk or limbs, *i.e.*, upon any portion of the

body, in accordance with the spontaneous autosuggestions of the patient or in accordance with suggestions from without, such, for instance, as may have their origin in a blow upon the back. They occur, curiously enough, relatively frequently in certain situations, such as a small oval area over the ribs just below the mammary gland and another small oval area immediately over the groin. Curiously enough, too, these painful areas are found more frequently upon the left side of the body than upon the right and possibly for the same reason that, as Babinski points out, hemianesthesia is also found on this half of the body. When found below the breast the area is sometimes spoken of as inframammary tenderness, and when found over the groin, as inguinal tenderness. This so-called inguinal tenderness at one time gave rise to much confusion. It was early termed ovarian tenderness, but experience soon showed that it had nothing whatever to do with the ovary. Time and again, in years gone by, the ovary was removed and yet, as a matter of course, the tenderness persisted. A brief investigation will always in a given case show the extremely superficial character of this inguinal pain and demonstrate that it is limited to the surface of the skin. The patient having been placed in the position for gynecologic examination, the index-finger of the left hand is placed immediately upon the painful spot on the groin. The index-finger of the right hand is then inserted into the vagina and its tip brought immediately below the tip of the index-finger of the left hand. Slight pressure between the tips of the two fingers now causes the patient to

flinch and complain of pain, just as she does when the area of inguinal tenderness is merely pressed upon on the outer surface. Other portions of the abdominal wall are then in turn included between the two index-fingers, and it is quickly demonstrated that the painful area is limited entirely to the abdominal wall. The finger within the pelvis can manipulate freely the uterus and the adnexa without causing the patient to give any evidence of pain. Moreover, the external and extremely superficial character of the pain can be still further demonstrated by picking up a fold of skin over the groin between the thumb and forefinger, when the patient at once complains of the pain.

Other areas in which hysteric pain and tenderness are relatively frequent are the skin over the tips of the spinous processes, the inferior angle of the scapula, the small of the back, and the scalp; sometimes an entire limb is thus affected, though more frequently the tenderness exists in isolated patches over the limbs and trunk. Sometimes it is the skin over the very tip of the coccyx which is the seat of the tenderness. When these areas are found upon the scalp, they are usually so small that they can be covered by the finger-tip, and are usually associated with a sensation of boring pain or as though a nail were being driven into the skull and, indeed, this symptom has given rise to the term, now no longer much used, of *clavus hystericus*.

No matter in what portion of the body the pain may be located, it is never associated with signs of organic or visceral disease. It is of special importance to bear this matter in mind, for occasionally the hysteric

painful area involves the nipple and adjacent portions of the mammary gland. Indeed, the pain complained of is often so great that the patient will demand an operation for the removal of the breast. Such a breast reveals, of course, nothing abnormal to examination, and in addition there are usually present numerous other evidences of hysteria, such as numerous painful spots or areas elsewhere and without relation to other organs or viscera; usually, too, there are the mental symptoms and other stigmata of hysteria, still to be considered.

Patches of painful tenderness may also be found upon the various mucous membranes, more especially upon the mucous membranes of the vagina and of the rectum. When present in the vagina, they may be limited to small areas which upon inspection reveal no change in appearance to the naked eye nor to any other examination. Sometimes the tenderness is diffused over the vagina as a whole and even shared in by the vulva. Such symptoms are usually associated with vaginismus, the patient declaring that it is impossible for her to have coitus because of pain and spasm. The purely psychic origin of vaginismus is well illustrated in an instance observed by the writer in which a young woman suffering from hysteria developed this symptom, during the continuance of which she refused to receive her husband. She was visited by a sister, also a young married woman. The patient's recital of symptoms was followed, in the sister, almost immediately afterward by an attack of the same symptoms, and the second patient likewise for a time refused to receive her husband.

At times patches of hysteric tenderness make their appearance in the rectum, the patient complaining excessively whenever the bowels are moved. At other times they make their appearance in the mouth or in the throat. It is characteristic, of course, that the most minute examination fails to reveal anything wrong. It is probable that in anorexia nervosa, a symptom still to be considered, painful areas make their appearance upon the mucous membrane of the stomach, the patient insisting that she has pain whenever any amount of food, no matter how slight, has been taken. Not infrequently too a hysteric patient will complain of pain in a joint. The patient will hold the joint in a fixed position and will complain of pain when attempts are made to move it. It was at one time thought in such instances that painful tenderness made its appearance upon the synovial surfaces, but there can be no doubt that the painful tenderness is limited purely to the skin covering and surrounding the joint, that it is a purely cutaneous symptom and has nothing whatever to do with the joint structures. Quite naturally painful hysteric joints most frequently arise in the lower extremities, due to the more frequent incidence of trauma and of fatigue in these members.

Motor Symptoms.—When we turn our attention to the motor phenomena of hysteria, we find that in given instances the patient believes that an extremity is paralyzed, or, instead of paralysis being present, there may be spasm of the muscles, fixed contractions, or there may be tremor or incoordination of movement. Like the sensory phenomena, the motor phe-

nomena cannot be referred to any organic lesion either, *i.e.*, they cannot be explained by any of the known facts of anatomy. A paralysis, like a sensory loss, may be limited and may involve merely a portion of a limb. It is never limited to individual muscles or to a group of muscles; thus if the arm be paralyzed, both flexors and extensors are involved. It may involve homonymous portions of the body and thus give rise to a paraplegia, or it may involve one-half of the body and give rise to a hemiplegia. Very rarely a general paralysis, involving both sides, is observed. The palsy is most commonly flaccid, though at times spastic in type. It may vary from a mere weakness to a total loss of power. As a rule, the tendon reactions are more pronounced than in the non-paralyzed limbs. The skin reflexes appear to be diminished and at times are altogether lost. Usually the nutrition of paralyzed muscles remains unaffected, but in cases of long duration some diminution in volume may be observed, although a true degeneration of the muscles never occurs. An electric reaction of degeneration is, therefore, never present.

When spasticity is pronounced it may give rise to a marked fixation or contracture. One of the most remarkable facts associated with hysterical paralysis is that the paralyzed limb is usually also anesthetic. For instance, if we examine a hysterically palsied arm, we find that the arm has also lost its sensation. In other words, the arm is cut out of the psychic makeup of the patient in its entirety; it is elided from the field of consciousness, both as regards motion and sensation. This association of

anesthesia with paralysis in hysteria is an almost constant finding and one that at once determines the nature of the paralysis. Sometimes we notice that a paralyzed area is somewhat edematous or that there is a bluish or mottled discoloration of the skin, a condition which the older French writers spoke of as "blue edema." This blue edema, which is occasionally met with in parts that are not paralyzed, may persist for a variable period; it may come and go. Usually it is not very marked. Hysterical paralysis may come on quite suddenly. It may come on suddenly as a result of a shock or trauma or it may begin as a slight weakness and gradually grow more pronounced until it becomes marked or complete. The effect of trauma is, as already indicated, most variable. A trivial tap upon a limb may result in a complete paralysis, while a severe destructive injury, involving it may be bones, joints, muscles, tendons, or nerves, may not be followed by any hysterical reaction whatever.

Hysterical paralysis is, as just stated, very variable in duration. Sometimes it is very persistent; especially is this the case when it has existed for a long time and when the association in the patient's mind with the supposed cause of the paralysis—*e.g.*, trauma—cannot for the time being be broken up or dispersed. This is noticeably the case in the hysterical palsies and other hysterical symptoms which make their appearance in predisposed individuals after railroad accidents. Here the palsy persists until the claim is disposed of, no matter what form of treatment may be adopted. The patient's arm, for example, remains paralyzed until the

case is actually settled, that is, the money actually paid over. Physicians are then no longer consulted and the paralysis soon disappears.

The palsies of hysteria, as already stated, point unmistakably to a mental origin. Thus, the hemiplegia presents features which enable us to distinguish it at once from organic hemiplegia. The arm is most frequently flaccid or nearly so; at least, it does not assume the position of secondary contracture usually met with in organic hemiplegia. Again, the paralysis is usually most marked in the leg, which is also usually somewhat rigid, but the latter is dragged in walking as though it were dead and absolutely helpless or, curiously enough, it is shoved in advance of the patient as he walks; the gait only superficially resembles that of organic hemiplegia. Further, the muscles of the face are never paralyzed. There is never any involvement of the lower half of the face, as in organic hemiplegia, and a total palsy of the face, such as is met with in Bell's palsy, likewise never occurs. The tongue at times deviates when protruded, but it always deviates not to the paralyzed, but to the sound, side, the reverse of that which takes place in organic ipsilateral hemiplegia. Again, the palsy in hysteric hemiplegia is equally marked in all of the segments of the limbs. In organic hemiplegia we know that this palsy, like the sensory loss, is emphasized or exaggerated in the distal portions of the extremities and less marked in the segments proximal to the trunk.

Hysteric paraplegia not infrequently occurs, but it is, as a rule, readily differentiated from organic paraplegia. If the patient with an

hysteric paraplegia is still able to walk, we find that the gait is spastic, but it lacks the characteristics of the organic spastic gait in that the soles of the feet are usually dragged or shoved along the floor. Further, there is no involvement of the sphincters and there is an absence of bed-sores and other trophic changes. Sensory disturbances also are commonly present, such as the stocking-like anesthesia already referred to. Finally, if the patient be lying in bed upon his back and he be asked to make an effort to raise, for instance, the right leg, the operator having placed his hand under the left leg, it is found that, as the patient makes an effort to raise the right leg, he *depresses the left leg* on the bed or *vice versa* when the attempt is made to raise the left leg. In other words, the paralyzed limbs are really moved by the patient, though in a manner of which the patient himself is not aware.

The contractures met with in hysteria only rarely simulate the contractures due to organic disease. This is particularly true of the secondary contractures of organic hemiplegia. In hysteric paralysis of an arm, for instance, the arm may in addition be contracted. The position adopted may be that of simple flexion, or some bizarre position may be assumed. This may also be observed in a leg, though here usually the tendency is to rigidity with extension. In the contractures of organic disease it is the distal portions of the limbs, *e.g.*, the hands and fingers, which suffer most. In the contractures of hysteria the limb usually suffers as a whole. Of course, the discovery of associated symptoms, such as anesthesia, or of

other sensory stigmata, such as painful areas, usually determines the diagnosis.

Tremor is every now and then observed in hysteria and may consist of to-and-fro oscillations of variable rapidity. The rate may vary from 4 to 12 in a second. Usually the rate is from 7 to 9 in a second. Quite commonly, too, tremor ceases when the patient is from under observation. It reappears, if absent, or becomes more marked, if present, when the patient finds himself under observation; the extent of the movements also increases. This is likewise true of the tremor when the patient makes a voluntary effort. Finally, the tremor resembles neither the tremor of paralysis agitans nor the coarse movements of multiple cerebrospinal sclerosis.

Inco-ordination of movement is less frequently met with in hysteria than either palsy, contracture, or tremor. However, when present, it may give rise to an awkwardness in the use of the affected extremity, such as an arm, and is then commonly associated with weakness, *i.e.*, with an hysterical palsy. The presence of anesthesia at once confirms the diagnosis. It may involve all of the extremities. Much more frequently, however, it involves the legs, and we then have present the picture of an hysterical ataxia or a so-called *astasia-abasia*. Inco-ordination usually becomes evident only when the patient attempts to make an effort; for instance, when he attempts to stand or to walk. When the patient is lying down or sitting in a chair, there is power to move the legs normally in all directions, but when the patient attempts to rise, the ataxia at once

becomes manifest, and if he tries to walk, it quite commonly becomes very pronounced. Hysterical ataxia, of course, is present in varying degrees. Not infrequently, however, it is quite marked. If the patient be able to walk, the gait does not resemble that of locomotor ataxia in the slightest degree. There is great irregularity of gait; wide, oscillatory, coarse, or grossly bizarre movements of the legs, arms, and trunk; quite commonly these phenomena are associated with a demeanor and conduct on the part of the patient as though he were afraid of falling.

Disorders of the Special Senses.—

When we turn our attention to the special senses, we find phenomena similar to those already considered. The most familiar instance is that in which the visual field is concentrically diminished, *i.e.*, the peripheral portion of the retina appears to be the seat of anesthesia. Every now and then the anesthesia involves the entire retina and then gives rise to hysterical blindness. Very rarely the anesthesia may be irregularly distributed and may simulate a hemianopsia. Contraction of the visual field is suggested to a hysterical patient with the greatest ease; everything depends upon the manner in which the examination is made. The test-object should invariably be carried from the center outward and the fact of failure to perceive it determined by indirect questions.

Quite commonly, it should be added, a contracted visual field is found on the side in which a hemianesthesia is found. At times, too, the limitation of the visual field assumes a character which at once demonstrates its psychic origin, *i.e.*,

the area of the contracted field remains of the same size whether the perimeter is held near or far from the patient, *i.e.*, a so-called tubular vision is observed. Such a modification of vision is obviously psychic. Another remarkable symptom is not infrequently noted in relation to the hysteric retinal anesthesia, and that is the so-called reversal of the color fields. In health the retina is not equally sensitive to the various colors in all portions; thus, violet is perceived in a relatively small central area, green in a somewhat larger area, red in a still larger area, yellow in a still larger, and blue in a still larger area. In hysteria the area in which blue is perceived may become contracted, so that it falls within the area in which red is still perceived; that is, instead of the largest field being that of blue perception, it is now that of red perception, blue perception being so far diminished as to fall inside the limits for red. It would appear that the sensitiveness of the retina to violet diminishes or disappears first, then to green, then to blue, the red persisting until the last. The loss of the color sense is part and parcel of the reduction of the visual field as a whole, *i.e.*, is a phenomenon of anesthesia and is likewise psychic in origin.

Similarly hysteric losses are met with referable to the ear. Hysteric deafness may follow trauma of the ear, may follow suggestion, and may be an accompaniment of a hemianesthesia. Quite frequently its unreal character can be demonstrated by means of a binaural stethoscope; the ends of the tubes being introduced into the ears of the patient, the operator stands back of the patient and

converses with the latter by speaking into the stethoscope in a low voice. The sounds are, of course, conveyed to both ears and the patient naturally replies to questions asked or complies with various instructions. If, now, the physician suddenly compresses the tube leading to the sound ear and the patient continues to hear, he must, of course, hear with the hysterically deaf ear. Usually hysteric deafness, like the loss of vision, is incomplete. Bone conduction is, of course, well preserved, though its existence may be denied and may not be demonstrated save by stealth. It is a remarkable fact also that hysteric deafness is quite commonly, if not indeed always, accompanied by anesthesia of the auricle, of the auditory meatus, and of the drum.

The senses of smell and taste may likewise be involved in hysteria. A patient who has a hemianesthesia may stoutly maintain that he is unable to smell upon the hysteric side or to taste upon this side. Sometimes such a loss of smell and taste are complained of by a patient who does not present the symptoms of a hemianesthesia. Such a patient when tested with various sapid substances will maintain that he does not taste them upon the affected side. If irritating substances, such as capsicum, or if physical irritation, such as pricks with a pin, be now applied to the tongue, the patient likewise denies that he perceives them. In other words, he confuses tactile loss with gustatory loss. Quite commonly we find anesthesia of the tongue, gums, mucous membrane of the cheeks, and lips on the side on which loss of taste is claimed. Similar remarks apply to the loss of the sense of smell. It also

is associated in the patient's mind with tactile loss, and no distinctions are made by him between loss of smell and loss of those sensations which convey physical or mechanical impressions.

Visceral Symptoms.—The visceral symptoms of hysteria are, like those already considered, of such a character as to demonstrate their psychic origin. Among these disturbances we have to note especially vomiting, anorexia nervosa, tachycardia, various vasomotor phenomena, rapid breathing, coughing, yawning, retention of urine, variations in the quantities of urine, phantom tumor, aphonia, spurious aphasia, and sexual phenomena.

Anorexia nervosa has already been fully considered in Volume II, page 1, of this Cyclopaedia. Suffice it to say that there is in this condition a more or less marked loss, sometimes a complete loss, of the desire for food. That this loss of the desire for food may be accompanied by loss of weight and may offer profound difficulties in the way of treatment, but that it may be overcome by suggestion and by forced feeding, has already been pointed out in the article above referred to.

Hysteric vomiting when present may be associated with anorexia nervosa and may be so profound as to simulate vomiting the result of organic disease. Pain may be referred to the epigastrium and may lead to the erroneous diagnosis of gastralgia. It may, further, be exceedingly limited in character and distribution and thus may simulate gastric ulcer. The patient may even spit blood and in this way simulate the bleeding of such an ulcer. However, the differentiation is, as a rule, made without

practical difficulties. There is really an entire absence of all genuine evidence pointing to organic disease, such, for instance, as is furnished by test-breakfasts or by a microscopic examination of the stomach contents. At most there may be some atony of the stomach or possibly a mild secondary gastric catarrh, but usually there is nothing.

Tachycardia is often observed as a complication of hysteria. This tachycardia may be, and frequently is, associated with localized flushings of the face, trunk, or extremities. Sometimes pallor and coldness of the surface of the body and the extremities may be noted. Hysteric rapid breathing is also occasionally observed. The increase in the rate of respiration may be very great; as many as 90 respiratory acts to the minute have been counted. It is not necessarily accompanied by tachycardia. Indeed, most frequently there is no disturbance of the pulse rate nor is there any dyspnea or any evidence of cyanosis. It need hardly be added that neither is there any evidence of any cardiac or pulmonary lesion.

Hysteric cough is a not infrequent symptom. As a rule, this cough is dry and is unaccompanied by any physical signs. Sometimes, instead of cough, curious cries or sounds are emitted, which suggest the barking of a dog, crowing of a cock, or other bizarre sounds. In other cases again frequent and excessive yawning may be observed. As a rule, the act of yawning is very greatly exaggerated and very prolonged. Hysteric sneezing should also be added to this category.

At times the patient loses his voice;

at other times he is mute, being apparently unable to speak. In both of these conditions, hysteric aphonia and hysteric mutism or aphasia, the signs themselves are of such a character and the other phenomena present usually so pronounced and unmistakable as to leave no doubt as to the nature of the symptoms.

Miscellaneous Somatic Symptoms.

—Among other symptoms, fever has been described as occurring in hysteria. Déjerine is one of the few recent writers who still believes in its existence; the author, however, after an experience of thirty years in the hospitals without observing a single instance, is compelled to deny its existence. Fraudulent tricks with the clinical thermometer he has met with, true fever never. Trophic disturbances have also been claimed. These, likewise, the author has never observed. So-called hysteric ulcers and other skin lesions disappear as soon as the patient's access to them is prevented by a plaster-of-Paris bandage or similar mechanical device. Now and then the muscles of a limb which has been persistently hysterically paralyzed for a long time show some diminution in size. This diminution is, however, never very marked, and results simply from disuse and cannot in any sense be termed trophic.

The localized swellings and edemas which are at times noted as occurring in connection with paralyzed limbs—never very marked—are likewise to be attributed to disuse and secondary circulatory disturbances. Local flushings, dermographia, and kindred phenomena are but part and parcel of the other circulatory changes admittedly the result of psychic and

emotional influences. Blushing, pallor, and other vasomotor perturbations can hardly be termed trophic.

The sphincters are now and then disturbed in hysteria, though such disturbance differs radically from that met with in organic disease. Very often the patient presents the symptom of unusual frequency of micturition. Less often he asserts that he cannot hold his water; however, if the clothing and bedding of such a patient be examined, it presents no evidence of having been soiled or stained nor is there any odor of urine. Willful deception may, of course, be practised. Now and then retention of urine is complained of, but it is a retention which is often not true and when neglected leads to no evil results. True paralysis of the bladder or sphincter, it need not be added, is never observed.

Many hysteric patients present the symptom of polyuria; such patients, as is well known, may pass a very large amount of urine, especially after an hysteric paroxysm or hysteric emotional disturbance. The urine in such cases is light colored and of low specific gravity. Less frequently cases of hysteria are met with in which the urine is greatly diminished in amount and in given instances the claim of an absolute anuria is made. That such claims are fraudulent goes without saying. Patients with hysteric anuria never, of course, present the grave symptoms associated with the actual suppression of urine; indeed, symptoms of suppression are conspicuous by their absence. Further, when such patients are observed by stealth, it is found that, although the night vessel is not used, it may be that a soap dish or pitcher or other

article about the room has been utilized and the urine subsequently surreptitiously disposed of when the patient believes herself from under observation. Such conduct on the part of the patient is in keeping, as we shall see, with other psychic phenomena not infrequently present.

Now and then we may observe an undue distention of the abdomen, so that the patient may present a superficial appearance of pregnancy. At times also, due to an irregular contraction of the abdominal muscles, the distention is irregular in outline and in this way a so-called phantom tumor may be produced. The physical examination, of course, reveals the nature of such phenomena. Now and then phantom tumors are due to a local contraction of a muscle; for example, to a contraction of a belly of the rectus.

A large number of cases of hysteria, more especially cases of traumatic hysteria, complain of sexual disturbances. Not infrequently men claim that they have become impotent. Women, as we have already seen, may complain of their inability to receive their husbands because coition is attended by suffering. Such cases, we should remember, are cases of vaginismus dependent upon superficial painful areas in the vagina. That there is a great field here for gross misstatement and willful deception need not be pointed out. Besides it is usually impossible either to verify or to disprove the assertions of the plaintiff. However, it has occurred in more than one occasion in the writer's experience that during the long delays pending trial, a woman making such a claim has become pregnant and given birth to a

child, thus proving the falsity of the claim. Similarly, in the case of men claiming to be impotent, their wives have borne children; for example, in the case of a man suffering from hysterical hemiplegia there were two trials. In the first the claim of entire loss of sexual power was made. For some technical reason a second trial was granted; the second trial was not reached for another year. In the mean time the wife gave birth to a child, the paternity of which at the second trial the plaintiff admitted. In another instance in which settlement was made largely on the basis of the impotence claimed, the wife gave birth to twins within the year.

Psychic Symptoms.—The symptoms of hysteria thus far considered bear the unmistakable impress, as has been insisted upon throughout this article, of a mental origin. The mental condition of the patient also has to some extent been discussed. It is necessary now, however, to consider in detail some of the psychic symptoms themselves.

The mental symptoms, like the motor, sensory, and visceral symptoms, impress us with their unreality and unessential character. In fact, there is something about them which even to the lay mind suggests their real nature. The simulation of abnormal mental phenomena is grossly imperfect. States of emotional excitement are very common, but the shrieks, screams, wild cries, and weeping deceive no one. At most a delirium or mental confusion may be simulated, but here, as in the case of the physical signs, the symptoms have the appearance of something that is not genuine, something assumed, something voluntarily and

artificially produced. This is usually quite obvious in the ordinary hysteric paroxysm. Hysteric attacks may vary greatly in intensity, as well as in the symptoms which they present. They may be limited to comparatively slight emotional disturbances attended by weeping and laughter, or by transient changes of speech and conduct in which the emotional factors are so evident that even the laity recognize the attacks as hysteric. Instead of being slight, the attack may be pronounced and even prolonged. Usually such an attack is preceded by a prodromal period extending over a number of minutes, several hours, or it may be over a day or two. During this period the patient frequently becomes depressed, avoids the members of her household, is uncommunicative, irritable, and perhaps is angry or weeps upon slight provocation. Less frequently the patient is excited, restless, perhaps a little exuberant or even boisterous, or she may laugh and weep by turns. Less frequently still, she acts as though she had frightening visions, sees strange faces and objects. Very commonly she complains of choking sensations, clutches at her throat, says that she cannot breathe, has headache or other distressing feelings. Rarely a picture suggesting a frank delirium is observed. Sooner or later a convulsion sets in. This convulsion is attended by a tonic spasm, during which the patient may present rigidity of all of the muscles of the limbs and trunk; at times, indeed, an opisthotonus, an "arc de cercle," may be present. Soon, however, the tonic spasm is followed by clonic movements, which are much greater in extent than those seen in epilepsy and of themselves usually

suggest a voluntary character. Hysteric attacks are of variable duration; some are brief, others more prolonged, and in the latter the patient may contort the body into various bizarre positions, or may make gestures and movements clearly expressive of volition and purpose. Sometimes the patient tears her clothing, dishevels her person, assumes dramatic and passionate attitudes, shrieks and weeps. Little by little she becomes quiet, submits to the ministrations of her friends, and conducts herself normally, or, perhaps, goes to sleep.

It is characteristic of the hysteric attack that during its continuance the patient does not lose consciousness, a fact that is rarely admitted by the patient, but commonly capable of convincing proof; sometimes the fact that the patient is conscious during the attack is self-evident. The patient never hurts herself and betrays by her actions or by her subsequent statements a knowledge of her environment. The sphincter control is never lost, nor is there ever any biting of the tongue, as in epilepsy.

Instead of subsiding, the attack may pass into a phase in which the patient seems to hear voices, to see visions, and in which she utters disconnected phrases, is exalted, depressed, erotic, obscene. At other times, the patient appears to pass into a condition resembling somnambulism. Contrasted with delirium due to an infection or an intoxication, a crass difference becomes apparent. The visions which the patient sees and which she dramatically addresses, give the bystander the impression of being assumed, not genuine. The illusions of persons and objects are often exhibited in such a way as to

give rise to the same conviction. The patient, being told that a certain person is her father, dramatically calls him by a strange name, and yet a moment later betrays that she knows exactly who the designated person is. Finally, neither the incoherence nor the delusions recall those of delirium proper. Long sentences and long phrases, at all times with a rich emotional content, replace the unrelated fragments uttered in the genuine affection. It must be admitted, however, that at times, though rarely, the hysteric delirium simulates the delirium due to other causes more closely. The patient not only sees objects from which she shrinks or toward which she makes movements of defense, but she also hears voices, to which she makes response.

The duration of a hysteric attack may be quite short, sometimes a few minutes, sometimes a few hours, rarely a day or more. Sometimes, instead of the patient becoming quiet and conducting herself in a normal manner, a confusion persisting over a number of hours may make its appearance. This confusion is sometimes exceedingly mild in character. At other times it is more pronounced and is to be looked upon as a continuation of the hysteric attack itself.

Instead of resuming a normal behavior at the end of an attack or of simply dropping off into a natural sleep, the patient may pass into a sleep which is very profound, from which it may be impossible for the time being to rouse her and which is sometimes spoken of as hysteric stupor or coma.

Sometimes a hysteric paroxysm manifests itself by a sudden onset of confusion without a preliminary con-

vulsive period. Sometimes, too, sleep or stupor may suddenly supervene in a similar manner, a condition termed hysteric narcolepsy. Such a sleep is variable in duration, extending over a fraction of an hour, a number of hours, or it may be over several days. Instead of being profound, it may manifest itself merely as a kind of lethargy.

Sometimes ecstasy or cataleptic phenomena are observed during a paroxysm; at other times, still, a somnambulism makes its appearance, the patient's conduct simulating the somnambulism of hypnotism. Occasionally such a somnambulism comes on spontaneously. In this state the patient may perform various acts, often complex in their nature, requiring considerable time and bearing no relation to the occasion or to the environment and during the performance of which the patient is entirely oblivious (?) of her surroundings. Such attacks usually terminate quite suddenly, the patient subsequently having no recollection (?) of what has occurred. Such symptoms can only be accounted for on the basis of a psychic dissociation. One group of ideas, as in the somnambulism of hypnosis, occupies the field of consciousness to the complete exclusion of all others; that is, there is a separation of the personality into two parts which have no relation with each other. Such a cleavage of the personality may be quite persistent, so that the patient, for long periods of time, acts exclusively under the influence of one group of ideas and associations, and subsequently acts under another group and conducts himself as though he were possessed of two personalities. While in one

state it would appear that he has no knowledge or recollection (?) of his experience while in the other. Such instances of dissociation are remarkable, but, after all, no more remarkable than the cutting out of an entire limb or one-half of the body from consciousness, such as occurs in the case of an hysteric palsy or hysteric hemianesthesia. One morning a young physician left his office to go to a hospital, with the outdoor service of which he was connected. He did not appear at the clinic nor was anything heard of him for two days. He suddenly came to himself on a country road, many miles from his home. He had no idea of where he was, or how he had gotten to the place at which he found himself. He had evidently purchased a ticket, boarded a train, gone to a hotel, paid for food and lodging; he had also apparently lost his straw hat, for, when he came to himself, he was wearing a cap; the latter was new, and it may be properly inferred that he had purchased it. Evidently he had committed no act which had been unusual, and nothing in his demeanor had attracted attention. The case of Ansell Bourne, reported by William James, is even more interesting, because the change to the abnormal personality was of longer duration and more complete. The patient was an itinerant preacher, who disappeared one morning from his home in Providence and reappeared two months later in Norristown, where, under a new name, he had conducted a small stationery store. He came to himself suddenly in a fright, and asked to know where he was. The case studied by Morton Prince, and the story of which is related by the

patient herself, reveals a still more remarkable instance of a dissociated or disintegrated personality. Regarding all such cases, however, a legitimate doubt of their genuineness may be entertained. Hysteric people often like to be interesting and enjoy occupying the center of the stage. That they practise gross deceptions in order to secure the sympathy and attention which they crave, every hospital physician knows. That they will simulate anuria, rise of temperature, or what not, that they will undergo severe procedures, face painful operations, in order to achieve this end, is a matter of common knowledge. That they may lie concerning so interesting a phenomenon as double personality is extremely probable. Further, human motive is sometimes very obscure, and the reason may not always be apparent why a man should conduct himself in a manner suggesting that there is a motive for concealing himself or, possibly, for making an entirely new start in life under entirely new conditions. Unfortunately, too, it is not always possible to separate truth from falsehood, and in no case is this more difficult than in hysteria.

In some cases of hysteria a serious and persistent pathologic attitude of mind may supervene. As already pointed out, visceral symptoms are not infrequent, and these may lead the patient to believe that she is seriously ill, that this or that portion of her body is seriously affected. Under these circumstances she develops an inordinate desire for sympathy and constantly demands medical attention. She recites her symptoms with a degree of minuteness that is painful and repeats the account with

much evident satisfaction, retails with endless elaboration her experiences with various physicians and various cures. Indeed, such a patient is not quite happy unless she is under the care of a physician or a surgeon. Sometimes the list of operations that such a patient has passed through is appalling, and may include in one and the same case removal of the appendix, of the ovaries, of the uterus, excision of the coccyx, sewing fast one or both kidneys. Such patients are among the most difficult with which a physician has to deal.

DIAGNOSIS.—The diagnosis of hysteria is to be based upon the cardinal feature of the psychic character of the symptoms. The sensory phenomena, the anesthetics, and more especially the painful sensory stigmata can be recognized with ease. The same is true of the motor phenomena and almost equally true of the visceral symptoms. The psychic symptoms are also easy of recognition. This is true alike of the paroxysm and of the interparoxysmal mental state. The hysteric fit is to be differentiated from epilepsy, for instance, by the fact that in epilepsy consciousness is invariably lost; in hysteria consciousness is never truly absent, though it may be perverted or possibly obscured for the time being. Again, in the hysteric seizure tonic contractions and rigidity predominate, not clonic movements, as in epilepsy. Further, the hysteric patient never bites his tongue, as does the epileptic, nor is there ever any loss of control over the sphincters, a very common occurrence in epilepsy. In the interparoxysmal period we have, first, the extreme susceptibility to suggestion, which manifests itself

by the ready acceptance of symptoms of all kinds and, secondly, a marked emotional instability. While it is easy to establish the presence of hysteria in a patient, the fact should not be forgotten that hysteria every now and then complicates actual organic disease. Further, the picture may be sometimes exceedingly involved when hysteria complicates another functional neurosis, such as neurasthenia, which it not infrequently does. In such an instance the patient presents the fatigue neurosis, to which the symptoms of hysteria have been added. Similarly, hysteria may complicate a true epilepsy, but such an occurrence is very infrequent.

PROGNOSIS.—The prognosis of hysteria is always favorable as regards the attack from which the patient is suffering. In the large majority of patients, suggestion is wonderfully efficacious in bringing about the disappearance of the symptoms. It is this fact which has led Babinski to invent a new name for hysteria, namely, "pithiatism," *πειθαιν*, "to persuade"; *ιαρός*, "curable," which means, literally, curable by persuasion. Quite frequently it happens that symptoms persist until certain causes which have to do with this persistence disappear. Notably is this the case with the hysteria of litigation. The courts are constantly filled with claimants who present the symptoms of hysteria, the latter having had their origin, according to the claim, in trauma, the claimant then being said to suffer from so-called traumatic hysteria. In such cases a palsy, a tremor, inco-ordination, or other symptom may follow a fright or a trivial blow upon some one portion of the trunk, head, or limbs; indeed,

pronounced hysteria may develop under these circumstances. Such a hysteria undergoes no change, even when the most radical efforts at cure are made. The symptoms persist indefinitely—if anything, steadily become more marked—until the case is settled, the money actually paid over, or the case otherwise legally disposed of. Very frequently, a hysteria which would rapidly subside if litigation ceased persists for months or even years. The fact that an injury resulting from a railway or other accident involves legal liability necessitates a closer questioning and more careful taking of records on the part of the physician, not only at his first, but also at his subsequent, visits, than is the case with ordinary patients. In due course again the claimant rehearses his symptoms in consultations with his lawyers, and many times repeats this rehearsal during the subsequent examinations by the medical experts. The patient is thus subjected to a kind of training, to a process which fixes the symptoms firmly in his mind; indeed, the symptoms always become more pronounced during the preparations for trial.

The methods pursued are pernicious in the extreme and utterly subversive of justice. It is noteworthy that if trial be not reached, or be for some reason postponed, the symptoms become less marked, and indeed often largely subside until the next date of trial approaches, when they again become more pronounced and often worse than before; indeed, new symptoms sometimes now make their appearance. These facts owe their existence to the renewed and repeated medical examinations and to

the rehearsals in the consultations with lawyers.

The true relation which the hysteria in such cases bears to the accident is shown by the history of these patients when their cases have been settled and litigation disposed of. Time and again experts testify upon the stand that a prolonged course of rest treatment is necessary to restore the patient to health, and yet the experience of the writer, extending over a quarter of a century and embracing many hundreds, if not thousands, of cases, fails to reveal a single instance in which, subsequent to the settlement of a case, the plaintiff submitted himself to a rest treatment. In other words, the plaintiff recovers when the element of litigation has been removed. All treatment ceases with the settlement; the symptoms disappear and the patient forgets all about them. It must be accepted as an established fact that the plaintiff neither gets well nor improves, no matter what treatment is adopted, so long as his claim remains unsettled or so long as there is any hope of settlement.

TREATMENT.—The first step in the treatment of a case of hysteria is the recognition by the physician of the fact of hysteria and the exercise of great care by him in studying the symptoms. The history of the illness should, as far as possible, be elicited from the friends and relatives of the patient and never in the patient's presence. Secondly, the study of the various physical stigmata should be made indirectly and every precaution should be exercised, if such symptoms are patently present, not to accentuate these in the patient's mind. The diagnosis can almost invariably

be easily established without making either prolonged or elaborate observations. Studies in which an anesthetic area is carefully mapped out or in which the exact limitations of a visual field are developed during a prolonged examination have, it is needless to say, a most injurious effect upon the patient. Equal care and reserve should be exercised in the studies of the various painful hyperesthesias. It is unnecessary to press hard or to press repeatedly over a given painful area and still less necessary is it to delimit its exact extent. Such a procedure is justifiable only when the significance or the character of the pain is doubtful or when there is really reason to suspect an underlying visceral disease. As a rule, visceral disease is readily excluded and the fact that the examination results negatively in this respect is frequently a great relief to the patient's mind.

Especially should the physician be careful to see to it that his examination is made in such a way as not to suggest the appearance of new symptoms; otherwise, great harm may be done. If the physician exercises due care in the manner in which his examination is made, his examination may give rise indirectly to suggestions which, instead of being harmful, are very beneficial to the patient. Such suggestions need not necessarily be made in words. Patients frequently present themselves to physicians with their special symptoms already well developed. The physician may tactfully recognize and admit frankly the special symptoms of which the patient complains, but he may reveal by his manner and by his general attitude in the examina-

tion that he does not consider these symptoms as serious or he may remark that he has often met with similar symptoms and has always seen them under proper treatment disappear. Now and then it happens that a hysteric patient is jealous of her symptoms, is anxious that the physician shall be duly impressed not only with their existence, but with their severity. Under such circumstances it is, of course, a mistake to minimize the symptoms unduly, at least at the first interview. If so, the patient may come to the conclusion that the physician does not understand her case, that he does not appreciate her condition, and that he has no sympathy for her, no feeling for her, and thus she may never give him a full share of her confidence. The proper examination of a hysteric person requires infinite tact, as much, if not more so than does the subsequent treatment. Every hysteric patient is anxious to detail her symptoms fully to the physician and, although the latter may already have received a full account from the relatives, it is important that he should appear to be both interested and sympathetic. My experience has convinced me that in cases of hysteria everything depends upon making a success of the first interview with the patient and during this interview the patient must be allowed to talk freely, long, and uninterruptedly. Little by little, questions of a general character can finally be ventured and gradually the patient can be led up to the point of the medical examination. It is important that this should be conducted, at first, not from the standpoint of the neurologist, but from that of internal medicine, and, the physi-

cian finding that nothing is revealed by his examination of the heart, of the lungs, of the abdominal viscera, or of the digestive tract, and dismissing each organ in turn, the patient is very apt to receive the suggestion that there is really nothing very serious the matter with her. Finally, if a good internal medical examination be made, organic disease, if really present, is revealed. If hysteric stigmata be present, they can readily be discovered during this visceral examination and by methods which do not impress their existence upon the patient.

If possible, the physician should get into close touch with his patient, for unless the patient gives him her confidence all of his efforts may fail. Except in the rare instances in which the opposite course shall be deliberately determined upon for special reasons, the suggestions of the physician as to the unimportant character of the nervous symptoms and as to their early disappearance should not be made bluntly or too emphatically. As far as possible the suggestion should be made indirectly and should, of course, be repeated at subsequent visits. The suggestions can, of course, be made in numerous ways, by word, by action, by silence, by relative inattention. After a time it is often expedient to ignore the existence of this or that symptom altogether. This is especially true of the sensory stigmata, and when one group of them begins to fade, as a rule all begin to fade. If a suggestion be made too directly, too openly, or too frequently, it may constantly keep the symptom before the patient's mind and thus, instead of aiding the physician to bring about a

cure, defeat his object. The appearance of indifference as to a symptom or set of symptoms must, of course, be avoided, and the exact course applicable to a given case must depend upon the individual judgment, good sense, and tact of the physician. Of one thing, however, he should make certain, and that is that every visit that he makes to his patient leaves her with the impression that she is getting better and that she will inevitably get well. The treatment of hysteria is essentially a treatment by **psychotherapy**, but, as Déjerine has only recently again pointed out, psychotherapy will fail unless the patient has confidence in and likes her physician. In relatively mild cases of hysteria, *e.g.*, office patients, such a system of psychotherapy may be all that is required. Quite commonly, too, it serves the purpose even in cases which the physician finds in bed. Every now and then, however, especially if the hysteria be marked, it is necessary to institute isolation,—isolation from friends and relatives, separation from a too anxious mother or daughter, from one who is constantly questioning the patient with regard to her symptoms and thus keeping the memory of them alive or who by the constant demonstration of her sympathy keeps the emotions of the patient, already unstable, in a condition of constant upheaval.

Quite frequently it is a good plan to institute a **rest treatment** such as proves so efficacious in the treatment of neurasthenia. Under such circumstances the patient is best treated away from home, in a private room, in either a public or a private hospital. The private hospital is, other things equal, to be preferred, because

of the more complete and effective isolation that can be instituted. Complete **isolation** is in many cases imperative and in given instances all communications with friends and relatives, whether by letter or indirectly by cards, flowers, or gifts, should be interdicted. No matter with what precautions such communications to a hysteric patient are surrounded, they inevitably do harm. Especially is this the case in the early part of the treatment. Later, when convalescence has been firmly established, flowers and books and the like may, according to judgment, be permitted.

If isolation be determined upon, a trained nurse becomes, of course, a matter of necessity. The nurse for the successful management of a case of hysteria must be possessed of certain important qualities. No matter how well she is trained, the physician should always explain to her beforehand the nature of the case and to some extent enter into the details of the symptoms which are present. The nurse should be instructed at first to play a passive rôle as regards the symptoms, to admit to the patient, if necessary, their reality and to observe them carefully. Under no circumstances should she, save under the instruction of the physician, attempt to suppress or to dispute the symptoms. Argument and vigorous methods are usually disastrous and otherwise objectionable. If the nurse at first minimizes the symptoms or what is still worse denies their existence, she never secures a hold upon her patient and her presence then in the sick-room does more harm than good. The nurse should endeavor by her conversation and demeanor to

keep up gently, day by day, the impression that the patient is getting well. However, she should avoid the rôle of a too sympathetic and pitying or too affectionate friend. How disastrous such a course is, need hardly be pointed out. Her attitude should be that of a calm, quiet, and cheerful companion whose business it is to carry out faithfully and without modification the instructions of the physician. Much depends upon the nurse; if deficient in tact, she is useless. The qualities which make a nurse successful in hysteria are usually inborn. Many nurses are utterly incapable of acquiring them. Some patients, for instance, need a little sympathy; they cannot get along without it; they will not improve without it. In other cases again the slightest exhibition of sympathy destroys the control of the nurse over the patient. It is best at first for the nurse to adopt an intermediate course, at least until she has gotten well acquainted with her patient.

In addition to suggestion, isolation, and the employment of a properly trained nurse, we should institute rest measures comparable to those used in neurasthenia. Quite frequently, because of the unphysiologic existence which she has led, the patient has suffered somewhat in general health and, in addition, therefore, to **rest in bed**, we should employ **liberal feeding** and supply the need of **exercise by massage and by electricity**; careful though not excessive use should also be made of **bathing**. **Physical exercise**, the character of which has been carefully determined,—especially when there are present motor stigmata,—is also under given conditions important.

In the majority of cases of hysteria in which the affection is so pronounced as to demand rest in bed, the rest should be absolute. As a rule, it is wise, as in neurasthenia, to permit the patient to leave the bed only to empty the bowels or to void the urine. As in neurasthenia, the **diet** should be simple and should contain comparatively small amounts of the carbohydrates, and but a moderate amount of the red meats. The white meats and succulent vegetables should be taken freely. Milk is also an important factor and should be given in increasing quantities, especially if the patient is below weight. Raw eggs may also be utilized just as in the ordinary rest treatment of neurasthenia. Special conditions may demand special modifications of the diet, as in anorexia nervosa and in hysteric vomiting, and how this can be combated was shown in the article on Anorexia Nervosa, in Vol. II, p. 7.

The **massage** should be given daily. We should bear in mind, however, that this procedure, which is so often calmative and soothing in neurasthenia, is often distasteful and irritating to hysteric patients, especially when areas of painful hyperesthesia are present. The massage should at first be gentle, later on vigorous, and should gradually be made deep and directed to the muscles. Areas of painful hyperesthesia should be carefully avoided at first, but little by little these areas should be encroached upon; before the patient is fully aware of it, they should be fully included in the rubbing. Many days may pass before this can be accomplished, but little by little such painful areas disappear and are literally rubbed out.

The **bathing** had best be very simple in character. Tub bathing or other forms of vigorous bathing should at first be avoided. A simple warm sponge bath between blankets, just as in the rest treatment of neurasthenia, answers every purpose. Later on, according to circumstances, douching, spraying, or the drip sheet should be employed.

Electricity may also be employed. The **slowly interrupted faradic current** may be used to stimulate the flexor and extensor muscles of the limbs and the muscles of the trunk; it is an adjuvant to the massage. Now and then the **rapidly interrupted faradic current** is used as a local stimulant and is often very efficacious in dispersing painful areas. The **constant galvanic current** can also be used for this purpose, the anode being applied over the painful area. If other forms of electric treatment are available, they may occasionally be employed with advantage. Among these are **static electricity**, the **sinusoidal current**, and **high frequency**. These methods can hardly ever be said to be necessary; they are to be looked upon as adjuvants in the way of suggestion.

The various visceral symptoms that may be present in a given case must be treated by appropriate methods, in which **suggestion** plays the leading rôle. Similarly anesthetics and palsies disappear rapidly under skillful suggestion, and this is also true of contractures. Pain, insomnia, and other symptoms, such as retention of urine, as a rule, yield rapidly to the administration of **placebos**. I know of no more powerful hypnotic in the insomnia of hysteria than a capsule of 5 grains (0.3 Gm.) of starch when

administered with a properly made suggestion.

The therapeutics of hysteria is, even when the patient cannot be adequately isolated, not a difficult problem. Quite commonly the success achieved is great and achieved without undue delay. In the experience of the writer, it is not necessary to resort to psychoanalysis. The latter, if it be of use at all, is of special use only in the psychasthenias, in the neurasthenic-neuropathic insanities in which the leading rôle is played by phobias and obsessions. Further, it is questionable whether in the case of a neurosis, such as hysteria, in which the affection is inborn and is part and parcel of the makeup of the individual, it is wise to question him with regard to the intimate personal facts of his sexual life. There is grave danger of suggesting new symptoms and of inextricably complicating the case. It is further questionable whether such a procedure is justifi-

able ethically, unless there be factors in the case which suggest that the symptoms are directly sexual in origin. Suffice it to say that simple psychotherapeutic measures, especially indirect suggestion coupled with simple physiologic procedures, yield results very promptly.

After the symptoms present in a given case have been brought under control or their disappearance brought about, the patient should be taken in hand and, whenever practicable, mentally retrained. To achieve this object, nothing is so valuable as an **occupation**, one that will actively interest the patient and develop and strengthen her best qualities both mentally and physically. Or, in other words, nothing will produce greater emotional stability than a wholesome occupation which fills the day with normal thoughts and feelings.

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I

ICHTHYOL.—Ichthyol (ammonium ichthyol-sulphonate) is a distillation product prepared from a bituminous mineral found in the Tyrol which is rich in fossilized remains of fish and sea-animals, whence the name "ichthyol" (*ἰχθῦς*, fish). By dry distillation of this bituminous mineral a crude volatile oil is obtained which, at temperature of 212° F., is treated with an excess of concentrated sulphuric acid, forming ichthyol-sulphonic acid. This latter substance unites with the alkaline bases (ammonium, sodium, lithium, etc.) and forms ichthyol salts, of which the principal ones are ammonium ichthyol-sulphonate (or ichthyol-ammonium) and sodium ichthyol-sulphonate (or ichthyol-sodium), the former being always understood when the term ichthyol is

used alone. These substances are rich in sulphur (about 15 per cent.), which is combined partly with oxygen, partly with carbon, in a condition similar to that existing in mercaptans and organic sulphides (Baumann).

Ichthyol, when pure, has a reddish-brown color and a bituminous taste and odor. The sodium salt is semisolid (of the consistency of a solid extract), and the ammonium salt is a thick, brown liquid of the consistency of syrup. Ichthyol should be completely soluble in water, and is almost entirely soluble in a mixture of equal parts of alcohol and ether. It is only partially soluble in alcohol or ether alone. It mixes well with lanolin, petrolatum, glycerin, fats, and oils, and with collodion and traumaticin.

PREPARATIONS AND DOSE.—Ichthyol is not official. The following preparations are used:—

Ichthyol (ammonium ichthyol), a syrupy liquid with a characteristic empyreumatic and burning taste. Dose, 3 to 30 minims (0.2 to 2 c.c.).

Sodium ichthyol (sodium ichthyol-sulphonate), a dark-brown mass, of more solid consistency than the preceding. Dose, 3 to 30 grains (0.2 to 2 Gm.).

Calcium ichthyol (calcium ichthyol-sulphonate), a brown, tasteless, insoluble powder.

Silver ichthyolate (ichthargan), containing 30 per cent. of silver and 15 per cent. of sulphur in organic combination, and occurring as a brown powder with faint, chocolate-like odor, freely soluble in water, glycerin, and dilute alcohol. Its solution darkens when exposed to light. Used externally in 0.04 to 3 per cent. solution.

Ichthyol albuminate (ichthalbin), a compound of albumin and ichthyol-sulphonic acid, occurring as a fine, grayish-white, odorless, and nearly tasteless powder, soluble only in alkaline liquids. Dose, 10 to 20 grains (0.6 to 1.2 Gm.).

Ichthyol formaldehyde (ichthoform), a compound of ichthyol and formaldehyde, occurring as a dark-brown, nearly odorless and tasteless powder, which is stable and insoluble in the ordinary solvents. Dose, 10 to 30 grains (0.6 to 2 Gm.); also used externally pure or in 10 to 25 per cent. ointment.

PHYSIOLOGICAL ACTION.—Ichthyol has antiphlogistic, anodyne, alterative, antipruritic, antiseptic, and astringent properties. Its peculiar virtues are largely ascribed to the large amount of sulphur it contains. According to Rudolf Abel, ichthyol acts more strongly against streptococci and diphtheria bacilli than staphylococci and other organisms. Solutions weaker than 50 per cent. should not be made for prolonged keeping.

When administered internally, although having a peculiar odor, it excites no nausea. In medicinal doses it is believed that it retards the disintegration of protein substances and favors their assimilation (Zuelzer, Charles). In larger doses it increases peristalsis and has a laxative

action. Helmers found that a third of the sulphur contained in the drug is eliminated by the urine, while the remaining elements pass out in the feces. He also found that the sulphur of the ichthyol takes at least seven days to be completely removed from the organism, and hence concluded that ichthyol does not simply pass through with the food, but is first absorbed into the system and then excreted.

When applied locally, it is said to act as a reducing agent (abstracts oxygen from the tissues) and to exert a peculiar constricting effect upon the vascular tissues; hence the application of ichthyol is followed by a diminution of heat, a reduction of swelling, pallor of the tissues, and relief of pain (Unna). Von Nussbaum has proved, moreover, that ichthyol, taken internally, benefits only those asthmatic affections, digestive disturbances, pelvic neuralgias, and sciaticas which are associated with anomalies of circulation and capillary dilatation.

Ichthyol undoubtedly inhibits bacterial development, as proved by the experiments of Fessler and Klein. Injected subcutaneously, it lowers the rectal temperature for about an hour (Dujardin-Beaumetz). When rubbed into the skin it is to some extent absorbed.

Untoward Action of Ichthyol.—While ichthyol is proverbially a soothing agent, in very exceptional cases it may exert a severely irritant effect; the explanations of this occasional variation have not been satisfactory.

A patient needed a mercurial ointment for application over an orchitis. To insure non-irritation of the thin, sensitive skin, the author prescribed 25 per cent. ichthyol as a diluent. For the first time in nearly thirty years of his experience the ointment acted as a violent irritant and speedily had to be removed. Heitzmann has known as weak a proportion as 10 per cent., in an ointment otherwise wholly bland, to blister within half an hour. No further explanation than "idiosyncrasy" has been advanced to account for these occasional results. The author suggests that among the immense pre-

ponderance of non-poisonous fish in the material from which ichthyol is derived there may remain a few, here and there, unsafe both for ingestion originally and for local application now. The continued poisons have become even more virulent with time. R. H. M. Dawbarn (N. Y. Med. Jour., Sept. 3, 1910).

THERAPEUTICS.—Ichthyol possesses many widely different therapeutic properties. Although not a panacea, it has established itself as a valuable aid in treatment.

Ichthyol can be used pure, or dissolved in any of the usual solvents. Internally, it can be administered in substance, in pill, capsule, or in watery solution (adding some essential oil to cover the taste). When given in pill form it is advisable to use sulphoichthyolate of sodium, the consistency of the latter better adapting it for this purpose. When it is given in solution, a mixture with an equal volume of water may be used; of this, 1 or 2 drops may be taken three times daily in a little water, the dose being gradually increased every three days by 1 drop, until 10 drops or more are being taken *t. i. d.* (not on an empty stomach). Should gastric pressure or a burning sensation be felt, it is an indication either that the ichthyol has been taken without sufficient dilution or that the maximum dose for the patient is being exceeded; usually the former is the cause. According to Vigier, after some days' use of ichthyol the stomach will tolerate $\frac{1}{2}$ to $1\frac{1}{4}$ drams (2 to 5 c.c.) of it.

Externally, ichthyol can be used in a spray, by inhalation, or in a gargle; in ointment, paste, dusting powder, or lotion; in vaginal, uterine, or rectal suppositories; in urethral bougies; on tampons; in watery or oily solutions, or as a varnish (dissolved in collodion or traumaticin). Unna, to produce an impermeable layer of ichthyol which can be easily and quickly removed without irritating the skin, uses the following: Ichthyol, starch, of each, 40 parts; concentrated solution of albumin, 1 to $1\frac{1}{2}$ parts; water, enough to make 100 parts. The starch must first be moistened with the water, the ichthyol then well rubbed in, and, finally, the albumin added. Ichthyol may also be

used in admixture with lanolin, zinc ointment, or glycerin, in strengths of from 5 to 50 per cent. For a regenerative action, according to Cranstoun Charles, weak ointments are better; for a resolvent action, as in gout, rheumatism, and neuralgias, strong ones are preferable.

When ichthyol is applied externally, previous washing (except when contraindicated, as in eczema) of the afflicted parts with soap and warm water, followed by gentle drying, is advisable. After the painting, inunction, or embrocation, it is best to cover the parts with carded cotton or flannel, and apply over all some rubber cloth or tissue, to prevent evaporation, repeating the process night and morning. To avoid staining the clothes, ichthyol may be applied pure and then dusted with French chalk to form a crust, the usual dressings being afterward applied. The odor of ichthyol may be disguised, if desired, by the addition of a small quantity of vanillin or cumarin, or of the oils of citronella, eucalyptus, or turpentine; the addition of 1 part each of oil of bergamot and oil of eucalyptus to 50 parts of ichthyol has also been recommended.

The remedy can be administered by subcutaneous injection in weak, watery solutions (1 to 3 per cent.), but if not freshly prepared the solution must be previously sterilized by boiling for a short time before using. For the hypodermic injection of exudates and tumors, solutions as strong as 50 per cent. have been employed. Injection of ichthyol is, however, no longer frequently resorted to.

The stains upon the clothing and bed-linen soiled during the application of ichthyol may be removed by boiling in soap and water, or by washing with soft soap or soap spirit, if this be attended to at once.

Ichthyol is useful in all forms of **rheumatism**, its application in these cases being followed by a prompt relief of pain and a diminution of swelling, redness, and febrile reaction. Dressings kept constantly moist with a watery solution (10 to 20 per cent.) of ichthyol have proved of considerable value in **acute arthritis**, **muscular rheumatism**, **lumbago**, **sciatica**, and **gout**.

If an ointment be preferred the following may be used:—

R *Ichthyol* fʒij-iv (8-16 c.c.).
Oil of citronella . gtt. xv-xxx.
Petrolatum or
lanolin ʒj (30 Gm.).

M.

In acute cases this may be gently rubbed over the affected parts and a piece of linen, spread with the same preparation, applied. This, in turn, is to be covered with cotton and a firm bandage. In sub-acute or chronic cases the ointment is best rubbed in well before applying the cotton and bandage. Ichthyol in olive oil (1:3) may be used in the same way. The effect of these applications, especially in sub-acute and chronic cases, can sometimes be heightened by giving ichthyol-sodium, 2 to 6 grains (0.12 to 0.4 Gm.), internally two hours after meals, either alone or in combination with an equal quantity of sodium salicylate.

In **acute rheumatism** ichthyol is helpful in the form of an ointment containing 1 dram (4 c.c.) each of ichthyol and salicylic acid to the ounce (30 Gm.) of lanolin, thickly applied to the painful joints and covered with absorbent cotton. In many cases of swollen and indurated cervical lymph-glands, ichthyol ointment will cause them promptly to subside. W. M. Gregory (*Cleveland Med. Jour.*, July, 1907).

By reason of its analgesic property, ichthyol relieves the **pain** of diseases other than rheumatism, as well as the **pain of inflammatory swellings**.

In all forms of **rheumatism** a lukewarm 10 per cent. solution of ichthyol-glycerin may be used to moisten a gauze dressing for the affected part of the body. A hot-water bag should also be applied if heat is desired. An ointment consisting of equal parts of petrolatum and wool-fat, with 6 per cent. of ichthyol and 1 per cent. of menthol added, acts extremely well. In patients who cannot bear heat, ichthyol may be applied in glycerin ointment form, protected by a compress. Such an application is especially

effective in cases of painful swelling, which it will often subside overnight. It is recommended in **gonorrheal rheumatism**.

Added to the bath, ichthyol gives good results in **neuralgia**, particularly neuralgia of the back. To a full bathtub 2 ounces (60 c.c.) of ichthyol should be added. The value of a salt-water bath is heightened by previous application of ichthyol on the affected part. J. Hirschkron (*Deut. Aerzte-Zeit.*, Nu. 1, 1907).

In **peritonitis** ichthyol has been applied pure, with a brush, over the whole abdomen. The surface is then covered by cotton, and that again by rubber tissue or thin rubber cloth to prevent evaporation. Pain, tenderness, tympanites, and fever subside under this treatment.

Scarpa treated a series of 150 cases of **pulmonary tuberculosis** with ichthyol, giving 20 to 200 drops daily of a watery solution of the pure drug (1:2) with the following results: 17 apparently cured; 50 notably improved; 32 improved to some extent; 28 not improved; 23 deaths. The beneficial action of the remedy was manifested first in the relief of cough, expectoration, and dyspnea, and later by an improvement in the general condition. Cohn calls particular attention to the remarkable effect of ichthyol on nutrition in this disease. He prescribes a mixture of equal parts by weight of ichthyol and water, and directs 4 drops to be taken well diluted three times daily. A little black coffee helps to cover the taste. The dose is to be gradually increased to 40 drops, which must be continued for a long time.

Ichthyol found serviceable in chronic **pulmonary tuberculosis** as the sole remedy in cases in which the hygienic surroundings of the patient could not be improved. Of 13 cases, 11 were distinctly bettered, and only 2 failed after prolonged treatment to show beneficial results. At the end of the first month of treatment the cough was less severe in the majority of cases, and all cases showed improvement at the end of the second month. In 8 cases the expectoration became less in amount, but at the end of two months night-sweats were

complained of more or less. At the end of six months all cases had gained weight. The drug was given in 4-minim (0.25 c.c.) capsules. As a rule, 2 capsules may be given four times a day, the amount being gradually increased until 5 capsules are taken at a dose, this being the limit. J. Burnett (Lancet, Aug. 8, 1903).

Ichthyol recommended in **pulmonary tuberculosis** in the early stages, **bronchitis** in all forms, and **pleurisy**. When given in doses as high as 20 minims (1.3 c.c.), three times a day, it tends to produce frequent bowel movements. It diminishes the discharge from the bronchi and hastens the return to a healthy condition, especially in patients who, having recovered from the acute bronchitis, still retain a cough, accompanied by profuse expectoration. The drug is probably rapidly broken up in the stomach, and acts as a stimulant to the gastric mucous membrane, promoting the flow of gastric juice, increasing the digestive power, and thus aiding in food assimilation. Patients who have done well under ichthyol immediately begin to show a greater desire for food. Because of its objectionable taste, it should be combined with ordinary peppermint water. The author adds a small amount of fluidextract of licorice, together with the peppermint water. It should be given after meals. A convenient form of administration is a tablet made up with 5 minims (0.3 c.c.). Barnes (Med. Rec., Jan. 21, 1911).

In **bronchiectasis** with fetid expectoration, and **acute bronchitis**, good effects have been reported from the use of ichthyol.

In **gynecological disorders** ichthyol has been used on account of its anodyne properties, its resolvent and absorptive action, and its kolyseptic powers. It has been found useful in the treatment of **chronic metritis**, inflammatory conditions of the tubes and ovaries, **erosion** of the **cervix**, **catarrhal endocervicitis**, **leucorrhea**, and **pruritus** of the genitals. Locally, a mix-

ture of ichthyol, 1 dram (4 Gm.), and glycerin, 10 drams to 2 ounces (40 to 60 Gm.), may be applied on cotton tampons. Usually a 10 per cent. mixture is used. The remedy may also be rubbed in over the abdomen in ointment with lanolin (1 to 4 parts), or combined with soft soap (1 to 8). Suppositories containing 1 to 4 grains (0.065 to 0.26 Gm.) of ichthyol may be administered *per vaginam*. Ulcerations and erosions may be painted with pure ichthyol. For **leucorrhea** lavage with a 5 to 10 per cent. watery solution is appropriate, or a 5-grain (0.3 Gm.) suppository may be used night and morning, preceded by a copious hot-water irrigation. Doisey found a 1:4 ointment effective in **pruritus vulvæ** in pregnant women after other methods of treatment had failed.

Ichthyol used as a laxative in 50 women suffering from various inflammatory affections of the genitalia, accompanied by constipation and dyspepsia. It was given in keratin-coated pills of 3 minims (0.2 c.c.) each, once, twice, or thrice a day. The **constipation** was overcome without colicky pain or diarrhea. Gunsburg (Northwestern Lancet, Feb. 15, 1900).

In **acute cystitis** the lower part of the abdomen may be painted with ichthyol, pure or in a 30 per cent. ointment, to relieve the pain. The bladder may then be irrigated once or twice daily with a warm (86° F.) aqueous solution of ½ per cent. strength. In **chronic cystitis** a warm 1 per cent. solution may be used once daily.

Gonococcal urethritis is amenable to intraurethral injections of a ½ to 3 per cent. watery solution of ichthyol or a 0.04 to 0.2 per cent. solution of silver ichthyolate. Neisser states that a 1 per cent. solution of ichthyol will destroy gonococci. Villetti has advised injection of a 2 per cent. solution from five to six times daily, gradually increasing the strength to 5 per cent. As the patient improves, the number of injections is diminished to one in the morning and one in the evening.

Ichthyol suppositories will usually cause inflammatory symptoms to disappear in the course of a **gonorrheal prostatitis** (Lohnstein). The injection of a small syringeful of a 10 per cent. solution into

the rectum three or four times daily has also been recommended.

In dermatology ichthyol is especially useful in those affections associated with atony and induration of the deeper layers of the skin, and in which pain or inflammation exists.

In **acne** Unna advises the use of a 50 per cent. watery solution of ichthyol, well rubbed in on retiring, and washed off with warm soap-water in the morning; during the day a weak solution of bichloride of mercury is used. In addition to the external use of the remedy, Unna gives it internally in doses of from 8 to 30 grains (0.5 to 2 Gm.) daily. In **acne rosacea**, with a tendency toward eczema, mild applications are used externally; where there is no such tendency, the remedy may be applied freely.

In **nervous eczema** ichthyol may be used internally and externally. For **erythema multiforme** and **lichen urticatus** Unna advises external applications of pure ichthyol or of strong solutions. In **intertrigo** a 10 per cent. salve or watery solution is beneficial; in **eczema marginatum** the same preparations are advised, with the addition of from 2 to 10 per cent. of salicylic acid.

In a severe case of **weeping eczema**, the entire body and limbs being involved, relief from the severe irritation and final cure were obtained by the local application of an ichthyol solution. This applies also to **scrotal eczema**. C. O. Courtright (Ellingwood's Therap., April 15, 1909).

Ichthyol is also used with advantage in the chronic stages of **keloid** and **lupus**. In the latter Unna recommends the following:—

℞ *Mercury bichloride* ... 1 to 4 parts.
Sodium ichthyol-sulphonate 5 to 10 parts.
Distilled water, enough
to make 100 parts. M.

In **eczema** of the female genitals von Schlen recommends the following paste:—

℞ *Ichthyol* 1½ to 2 parts.
Powdered starch,
Flowers of zinc,
of each 12 parts.
Petrolatum 25 parts. M.

Itching in connection with eczematous conditions of the anal and genital regions can be greatly relieved by the use of an ichthyol wash ranging in strength from 1 to 2 drams (4 to 8 Gm.) to the ounce (30 c.c.) of water (Cantrell).

Ichthyol baths employed in different skin affections with good results; 250 to 300 minims (15.6 to 18.7 c.c.) of ichthyol are to be poured into the bath. The drug dissolves quickly. In **gonorrheal rheumatism** 500 to 600 minims (31.2 to 37.5 c.c.) should be used. The patients do not find it disagreeable to remain in the baths from four to six hours. Baths of long duration give the best results. They were found useful in **scabies**, especially in children; staphylococcic and streptococcic infections; **pruritus**, **pityriasis**, **psoriasis**, and **eczema**. DuBois (Rev. méd. de la Suisse rom.; Med. Bull., Feb., 1908).

In **variola** an ointment composed of 10 parts of ichthyol, 60 of some fat, and 20 of olive oil and of chloroform or glycerin may be rubbed in three times a day as soon as the papules became visible.

In **erysipelas** ichthyol has proved of great value, reducing the congestion, swelling, and pain, and apparently limiting the extension of the disease. The thickness of the skin determines, in a measure, the strength of the application to be used. The surface should be carefully washed and dried, and a salve (30 to 50 per cent.) made with lanolin or petrolatum then gently rubbed in. For use on the lower extremities Unna advises the following: Ichthyol and ether, of each, 1 part; collodion, 2 parts. Another formula is ichthyol, 2 parts, with ether and glycerin, of each, 1 part; or, instead of the foregoing, a 1:3 watery solution may be applied two or three times daily. The application should cover a zone of healthy skin around the affected area and always be made from without inward.

In **burns** of the first and second degrees subsidence of pain and congestion follows when pure ichthyol painted on. The use of an ointment composed of equal parts of ichthyol, zinc oxide, and petrolatum also produces a happy effect. Leistikow, in burns of the first degree, uses a mix-

ture of 5 parts of zinc oxide, 10 parts of magnesium carbonate, and from 1 to 2 parts of ichthyol; and in burns of the second degree a mixture of 5 parts of zinc oxide, 10 of prepared chalk, 10 of starch, linseed oil, and lime-water, and from 1 to 3 of ichthyol. This is applied once daily. Where there is much inflammation the two preparations can be used at the same time, the burn being first dusted with the powder, and the paste applied over it.

In **frost-bite** Lange recommends the use of ichthyol in olive oil (3:20) as a paint; Heuss advises ichthyol in camphorated oil (1:4), rubbed in once or twice daily, and covered with cotton.

In **chilblains** (pernio) the use of an ointment of ichthyol (10 to 30 per cent.) or of equal parts of ichthyol and turpentine is attended with good results. Unna advises the use of a mixture of ichthyol, 5 parts; chloroform, 2 parts, and petrolatum, 3 parts. If the skin is broken the chloroform is omitted, and zinc ointment replaces the petrolatum with advantage.

In **furunculosis** solutions or ointments of ichthyol (10 to 50 per cent.) are equally efficient; the inflammatory symptoms usually promptly subside, and, if applied sufficiently early, ichthyol will abort the boils. With the external treatment calcium sulphide may be given with advantage in $\frac{1}{4}$ -grain (0.016 Gm.) doses every two or three hours for twelve hours, then three or four times a day.

Pure ichthyol thickly painted on **furuncles**, which rapidly became softened and soon afterward opened. Every day the ichthyol was washed off and a new layer applied, after washing away the pus. The method proved equally successful in **sycosis barbæ** and **folliculitis of the scalp**. Several cases of **impetigo vulgaris**, **ecthyma**, and **eczema impetiginosum** were treated very satisfactorily with undiluted ichthyol. Hodara (Monats. f. Dermat., 1901; Merck's Arch., March, 1902).

In **pruritus** Lange advises the use of a mixture of ichthyol, 2 parts, in absolute alcohol and ether, of each, 9 parts; this is to be either painted on or rubbed in.

Incised and postoperative wounds dressed with pure ichthyol heal by first

intention. **Cracked nipples** heal well under a 20 per cent. ointment, but it must be wiped off before nursing. **Fissure of the anus** and other anal lesions do well under the use of pure ichthyol applied by means of a camel's hair pencil morning and evening and after defecation.

In **simple cellulitis** the author uses gauze saturated with a 20 per cent. solution of ichthyol in glycerin. This is applied to the parts and covered by a rubber cloth and cotton bandage. In a few hours the temperature falls, redness disappears, and pain is markedly decreased. In suppurating cases the gauze is pushed into the opening or openings, acting as a drain for the various pockets. The ichthyol solution may be injected directly into the **abscess cavities**. By its use one obtains better cicatrices, the danger of nerve implication is diminished, and loss of tendons and muscular attachments is avoided. A. Marro (Giorn. della Accad. di med. di Torino, No. 20, 1906).

In cases of **sore** and **cracked nipples** ichthyol ointment is a most healing application. It must be carefully removed before each nursing, then reapplied. W. M. Gregory (Cleveland Med. Jour., July, 1907).

Ichthyol suppositories are very useful in **rectal fissures**, **fistulæ**, and **hemorrhoids**. In **vulvar pruritus** the following formula (Barduzzi) proved effective: Ichthyol, 10 c.c. ($2\frac{1}{2}$ drams); menthol, 1 Gm. (15 grains); dermatol, 5 Gm. ($1\frac{1}{4}$ drams); petrolatum, 50 Gm. ($1\frac{3}{8}$ ounces); two or three applications a day.

In **eczema** the following ointment may be used: Ichthyol, 10 c.c. ($2\frac{1}{2}$ drams); lanolin, 40 Gm. ($1\frac{3}{8}$ ounces); oil of bergamot, q. s. Chesner (Quinzaine therap., Aug. 10, 1908).

Stings by venomous insects may be advantageously treated by the application of pure ichthyol, or of a mixture of equal parts of ichthyol and lanolin. If swelling already exists, sheet rubber may be placed over the ichthyol and an ice-bag laid over the rubber tissue.

Sprains and painful injuries about the

joints do well under ichthyol; it should be well rubbed in on the surface of the injured parts, covered with cotton, and a bandage then firmly applied.

The pain in **parotitis** subsides rapidly when the parts are anointed with ichthyol-lanolin (1 to 2 per cent.) and covered with cotton. In many cases the use of undiluted ichthyol is indicated (Lange).

Ichthyol is an efficient remedy in many affections of the mucous membranes. Heitz recommends a 2 per cent. solution of ichthyol as a gargle in **pharyngitis** and **tonsillitis** of almost every kind, except the follicular variety.

Ichthyol ointment, 2½ to 10 per cent., is advocated in the treatment of **scrofulous blepharitis** by Luciani.

Ichthyol in pills (¾ to 3 grains—0.048 to 0.2 Gm.—in twenty-four hours, rapidly increased to 10 or 15 grains—0.65 to 1 Gm.—in the day) is considered by many a valuable remedy in **whooping-cough**.

Gadde found that when ichthyol is given internally in **chronic alcoholism** the appetite returns and the **chronic gastric catarrh** is greatly improved. As secondary effects sleep is favored and general depression lessened.

In pills, capsules, or diluted with water, ichthyol affords immediate relief in **chronic catarrh of the stomach**, doing away with the discomfort attending the process of digestion, and relieving the accumulation of gases. J. Hirschcron (Deut. Aerzte-Zeit., Nu. 1, 1907).

Ichthyol meets admirably the indications in the **catarrhal conditions of the stomach in alcoholic cases**. Patients object to taking it for a few days, because of the sulphuric eructations, but it arrests all gastric fermentation within three or four days if taken regularly, and then it is no longer objectionable.

There is no advantage in putting ichthyol up in capsules. It is best used in a 25 per cent. solution and this should be further diluted when it is given.

The following formula has been the most satisfactory in the author's hands:—

R *Ichthyolis* ʒj (30 c.c.).

Benzosulphinidi,

Sodii bicarbonatis,

āā gr. iv (0.26 Gm.).

Aquæ cinnamomi. ʒij (60 c.c.).

Aquæ.....q. s. ad ʒiv (120 c.c.).

M. et ft. sol. Sig.: One teaspoonful before each meal.

G. E. Pettey ("Narcotic Drug Dis. and Allied Ailments," 1913).

Ichthyol in 1 per cent. solution used for lavage of the **stomach in ulcer and cancer** of this organ. The fluid is retained from ten to thirty minutes; the tube should not be withdrawn during this time; otherwise, vomiting may be induced. The toxicity of the stomach contents after a test-meal is greatly reduced already after 5 or 6 irrigations, and symptomatic improvement—unobtainable with ordinary lavage alone in the author's cases—follows 12 to 15 irrigations. A clinical cure in cases of gastric ulcer is obtained in a relatively short period. In patients with **hemorrhage**—not too severe—the ichthyolated water is given with addition of 1:1000 epinephrin solution; improvement follows day by day in the hemorrhage, which finally yields completely to the lavage, together with a suitable diet. In **inoperable cases of gastric cancer**, or where operation is refused, with the pylorus still patent, greater benefit is derived from the ichthyol lavage than from ordinary lavage or other drugs; the general prostration is distinctly lessened by the ichthyol. In hundreds of cases no untoward effect was noted, save occasionally—in cases of pyloric incontinence, in particular—mild diarrhea and slight pain. Constipation, where present, is always favorably influenced. A. Conti (Semaine méd., Jan. 21, 1914).

W. and S.

ICHTHYOSIS.—This is an hereditary or congenital, hypertrophic cutaneous disease, characterized by a general or localized dryness or scalliness of the skin, and a variable amount of papillary hypertrophy.

SYNONYMS.—Fish-skin disease; porcupine disease; xeroderma ichthyoides; ichthyose (F.); Fischschuppenausschlag (G.); ittiosi (I.).

VARIETIES.—Two varieties are usually mentioned: Ichthyosis simplex and ichthyosis hystrix, the difference being mainly one of degree, the latter being the severer form. A second classification is based upon the location of the disease, as ichthyosis cornea, follicularis, linguæ, etc. A third is based upon certain characteristics: Ichthyosis nigricans, a form in which the scales assume a blackish tint; striata, a form in which large masses of scales are thrown off; serpentine, occurring upon the back and abdomen, characterized by thick, yellowish-gray scales, and nitida, a form in which the scales have a pearl-like appearance (Alibert).

SYMPTOMS.—While ichthyosis may be generally distributed over the entire surface of the body, it may, on the other hand, affect only circumscribed localities. In intensity it may vary from an abnormal dryness of the skin to a well-marked and disfiguring disease.

Ichthyosis Simplex.—The mildest form has been designated xeroderma, or dry skin, and is the form most often met with. In this form the entire surface is not only dry, but also wrinkled, harsh, and poorly nourished, giving it an unnatural and occasionally a parchment-like appearance. The subcutaneous fat is apparently deficient in amount, and this intensifies the natural lines and furrows and favors the production, more or less, of scales, which may be small, thin, and furfuraceous, or large, thick, and of the appearance of fish- or alligator- scales. The former are usually seen on the head, the latter on the extremities, where they appear as polygonal or diamond-shaped plates separated from each other by lines or furrows. Their attachment is usually firm in the center, more loose at the periphery. When thin they are white, but when thicker the color may vary from a dirty grayish white to yellowish green, brown, or even black, the coloration being due to dirt, extraneous matter, and pigment granules. The character and duration of the disease, the age of the patient, the fre-

quency of baths, and treatment will influence the extent and amount of the scales.

Ichthyosis Hystrix.—This variety is a severer or exaggerated form of the milder variety. The line of demarcation is not always well defined. It may be confined to localized patches or be unequally distributed over part or all of the surface, and, occasionally, over certain nerve tracts (ichthyosis linearis neuropathica). On the affected parts are found irregular or polygonal masses of all tints, generally greenish and black, separated distinctly by the natural lines and furrows of the skin. If these masses be removed a dry and shriveled skin is exposed, beneath which the sebaceous ducts can be seen distended by plugs of sebum. Occasionally the patches present a rough, papillary, or warty growth, having a horny, pointed, round, or spinous appearance, the latter often being several lines in length, and, from its resemblance to the quill of a porcupine, this form has been termed hystrix (Shoemaker). The favorite seats of these patches are around the elbows, the back, the neck, the axillæ, the umbilicus, the knees, and the ankles. The factors in the severity and the development of the disease are the age of the patient, the duration of the attack, and the attention given to the removal of the masses.

The disease, while it may be congenital, does not usually manifest itself until the first or second year, when it is apt to appear upon the surface of the limbs, especially the elbows and adjoining parts, the knees, and the ankles. The disease may be limited to the palms (i. palmaris) or soles (i. plantaris), or may spread over the whole body—the usual course. In the latter case the entire surface may have the appearance of being sprinkled over with meal, the thick, rough, and scaly condition being marked on the extensor surface, while the flexor surfaces are ordinarily normal in appearance. The scalp is rough, dry, and covered with furfuraceous or branny scales. The hair is rough, dry, brittle, and deficient in luster. The eyebrows and eyelids may be slightly scaly, but are usually unaffected, while the face may be covered with plates. As a rule, little or no itching is

present. The disease usually runs a chronic course, being worse in winter.

DIAGNOSIS.—The characteristic features of ichthyosis are the history of the disease, the harsh, dry skin, furfuraceous scales or polygonal plates, its distribution, the dull-white appearance of the skin, with absence of redness and itching, which are usually sufficient to differentiate it from other cutaneous disorders. Mild cases might, however, be confounded with squamous eczema, and localized patches of old cases with seborrhea. In the latter disease the skin is well nourished, and there is no papillary hypertrophy, and the scales cover the dilated ducts of the sebaceous glands.

PATHOLOGY.—In a well-marked case the epidermis is greatly thickened by the accumulation of heaped-up lamellæ. The mucous layer is hypertrophied and slightly separated from the stratum corneum. The papillæ are enlarged and infiltrated with cells. The blood-vessels are enlarged, but the glands and follicles remain unchanged. In more advanced cases Neumann, in addition to other hypertrophic changes, has found the vessels dilated, the cutis thickened, and its connective tissue condensed in bands; the hair follicles lengthened and containing lanugo; an increase in the external root-sheath; the glands dilated, especially the sebaceous, which assumed a cystic form, and the subcutaneous fat diminished. In some typical cases the epidermis was lamellated, the color varying from yellowish to dark brown, and the hair follicles and sebaceous glands were absent. Kaposi reported a case in which both the sweat and sebaceous glands were absent. The follicular orifices often contain horny plugs.

ETIOLOGY.—Ichthyosis is a congenital or hereditary disease developing about the first or second year of life. Schamberg attributes its cause to a developmental and nutritional defect of the skin, with disturbance of the sebaceous and sudoriparous functions.

Variations in the oiliness and dryness of the human skin are very considerable, though not often very noticeable. The lubricity of the skin is greatest in adolescence and early adult life, diminishing with age. Ex-

treme dryness of the skin is less frequent; it is met with in the old as a part of the general atrophy of the skin, with lessened glandular activity. It is also met with in very thin skinned persons, in whom the physiological exfoliation is not sufficiently compensated for by growth from beneath; the use of much or poor soap aggravates the condition. In certain persons this dryness of the skin becomes so marked as to be considered a disease—"ichthyosis." It commences in intrauterine life, but is usually in abeyance until some months after birth, after which it manifests itself with ever-increasing aggressiveness. Whatever may be its hidden cause, it must be regarded as an exaggerated development of epidermis, or a hyperkeratosis with atrophy of the deep layers of the rete mucosum. Any inflammatory appearances are probably accidental rather than inherent. Its essence consists in undue retention of the corneous layer, exfoliation being in abeyance. W. A. Jamieson (Brit. Med. Jour., Feb. 16, 1907).

PROGNOSIS.—The prognosis is unfavorable as to cure. Proper treatment may, however, afford considerable relief. Ichthyosis usually continues throughout the life of the patient, and he should be so informed.

TREATMENT.—The indications for treatment are the removal of the scales and the softening of the skin. Internal treatment is useless except when the patient is anemic or ill nourished. In the latter case tonics (iron, quinine, strychnine, arsenic, codliver oil) and nutritious diet, chiefly of milk and eggs; open-air exercise, and exposure to a moderate degree of sunshine will be beneficial.

Local treatment is the more important and beneficial. Frequent baths, either simple warm baths or alkaline baths (sodium bicarbonate, 4 to 8 ounces—125 to 250 Gm.—to each bath), and at intervals a hot-air or vapor bath, simple or medicated, are of value; in any case the bath should be followed by the inunction of some oily or fatty substance (olive oil, sweet-almond oil, petrolatum, benzoated

lard,—alone or combined with an equal part of **lanolin**,—**glycerine** and **rose-water**, **cocanut oil**, etc.), the skin having been previously well dried.

In the treatment efforts must be directed to promote and secure regular systematic exfoliation of the unduly adherent and effete horny cells. Sulphur thins the epidermis, but adds to the dryness and is apt to set up inflammatory changes. **Resorcin**, however, not only favors continual desquamation, but tends to leave the underlying surface polished and pliant. Combined with starch and glycerin (the **resorcinized glycerite of starch**), it proves beneficial in all cases if begun early enough and steadily persevered in. A **superfatted soap** to which **resorcin** and **salicylic acid** have been added must also be used. Internal remedies are of little use in ichthyosis, the only one of service being **codliver oil** in small doses at night. W. A. Jamieson (Brit. Med. Jour., Feb. 16, 1907).

Case of ichthyosis occurring in a woman 26 years of age in whom portions of the palms and soles were the only parts not affected by the disease. The patient had also lost most of her hair and eyebrows. Under the **thyroid-extract** treatment, **alkaline** and **bran baths**, and **olive-oil inunctions**, she improved very much, but on neglecting the treatment she soon relapsed into her former condition. Shelmire (Texas State Jour. of Med., Feb., 1907).

Case of diffuse congenital ichthyosis, with myxedematous appearance, in a man of 21, cured by **thyroid** treatment, together with **baths** and local applications. Nordmann and Badet (La Loire méd., Oct. 15, 1910).

The use of **thyroid gland** is advised by Henrichs (Norsk Mag. f. Laegevidensk., Oct., 1920), on the basis of the genealogy of 7 families in which an inherited taint manifests itself in idiocy and ichthyosis in different members of each generation and sometimes both in 1 person. In 1 instance the disease is traced back 200 years. The records show from 8 to 16 members

in each family thus affected in the course of 4 or 5 generations.

In severe cases Schamberg advises **friction with soft soap** (sapo mollis), twice daily for four or five days, followed by a bath, and the inunction of the following:—

R *Acidi salicylici* gr. xl (2.6 Gm.).
Olei cocos ℥viiij (250 Gm.).
Olei lavandulae q. s. M.

Milton and Duhring recommended an ointment of **potassium iodide**, 10 to 20 grains (0.6 to 1.3 Gm.), and lard, 1 ounce (30 Gm.).

Shoemaker recommends an ointment of **benzoic acid**, 5 grains (0.3 Gm.); **rose-water ointment**, 1 ounce (30 Gm.), and **hydrous wool-fat**, ½ ounce (16 Gm.). Another favorite is **oil of ergot**, 3 ounces (90 Gm.), and purified **wool-fat**, 1 ounce (30 Gm.).

In ichthyosis hystrix, **caustics**, the **knife**, or the **Paquelin cautery** may be necessary to remove the hypertrophic tissue (Schamberg).

Eucerin, a new ointment base, obtained from wool-fat, is recommended by Unna for the treatment of ichthyosis. **Sulphur**, **resorcin**, **salicylic acid**, and **naphthol** have been shown to be of value.

Glycerin, as a useful remedy in ichthyosis, was first recommended by Lailier and has become the classical method of treatment in France, used either in the form of an ointment or as a 10 per cent. glycerine and water application after a daily bath with soap. The disadvantage of this latter method, which has otherwise much to recommend it, is an unpleasant feeling of stickiness and refrigeration.

Eucerin was tried in the form of a **eucerin cold cream** after baths with the addition of **salicylic soap**, and produced a gratifying result. Later attempts confirmed this good opinion. Editorial (Boston Med. and Surg. Jour., June 20, 1912). W.

ICTERUS. See LIVER, DISEASES OF.

ILEUS. See INTESTINES, DISEASES OF: INTESTINAL OBSTRUCTION.

IMPETIGO CONTAGIOSA.

—**DEFINITION.**—This is a contagious, acute, and inflammatory disease of the skin, characterized by flat, superficial, and usually discrete vesicles, which soon become pustular, then dry as thin crusts, which are soon shed, leaving a temporary reddish stain.

SYMPTOMS.—This is one of the commonest of the transmissible diseases of the skin. It is common in schools and institutions for children, where it often rapidly disseminates, especially in children under 10 years of age. It may also occur in adults, several members of a family being often affected.

It is characterized by pinhead to pea or finger-nail sized, round vesicles or blebs, which tend rapidly to pustulation. These are thin-walled, superficial, and flat. Their fluid is at first a clear serum, but in twelve to twenty-four hours it becomes puriform, drying into ochre-yellow or brownish, friable and crescentic crusts, surrounded by practically no areola and which appear to be "stuck on." The eruption is discrete, although rarely it may coalesce. Under the crust is a superficial erosion, which soon heals after shedding, the former leaving a temporary reddish stain, which fades.

The face, neck, and hands are the regions most commonly affected. In children paronychia, due to contact of the fingers with the facial lesions, is common. The mucous membranes are nearly always exempt. The eruption may be profuse or consist of a few lesions. When profuse, there may be slight rise of temperature.

ETIOLOGY.—Impetigo contagiosa may be transmitted from one individual to another by direct contact or through the mediation of certain articles. Moreover, it may be transferred in the same individual from one part of the body to another. In other words, this affection is both contagious and autoinoculable. It is further generally recognized that the disease is due to the invasion of the skin by the common pyogenic cocci or organisms morphologically indistinguishable from them. There is, however, considerable difference of opinion as to whether the offending agent is the *Staphylococcus aureus* or the *Streptococcus pyogenes*.

The staphylococci are nearly always present in the fluid of the vesicles, but investigations have pointed out that they may develop secondary to the streptococci. Clinically, one fact is obvious, namely, that the mere presence of staphylococci upon the skin does not suffice to produce impetigo, for they are to be found normally in the integument. Furthermore, all forms of pus (although practically always containing staphylococci) are not capable of determining an impetigo. Either the staphylococci are not the specific cause of impetigo, or they require a heightened virulence to enable them to produce the disease.

In armies there are types of impetigo which present features not commonly seen in civil life. These include a form of streptococcal impetigo commonly met on the buttocks and lower limbs, a type which causes a great deal of destruction of tissue.

W. H. Brown (Brit. Jour. of Dermat. and Syph., Dec., 1917).

It is possible that the soil itself may play some rôle in the production of the disease. In furuncles this is admittedly the case, and boils represent merely a deeper pyogenic infection. Impetigo is far more common in the poor than among the wealthy classes. Consequently it is a disease much more frequently seen in dispensary practice than in private practice. It is commonly observed as a complication of pediculosis of the scalp, the itching leading to scratching and the latter to pyogenic infection. Purulent discharges from the nose, eyes, or ears may give rise to the disease. It is common in infants during the summer months, when it occurs as a complication of prickly heat, with furunculosis frequently superadded. It is engrafted upon the vaccine wound and the multiplicity of lesions may lead to a suspicion of generalized vaccinia. The bearded portion of the face is commonly affected when the disease occurs in men. This region is frequently abraded in the process of shaving and offers easy ingress to micro-organisms. The focus of dissemination in many epidemics is traceable to certain barber-shops, and in such cases it is usually found that the care of the instruments employed is defective.

It is not, however, the "barber's itch," which is due to ringworm (Schamberg).

TREATMENT.—According to Schamberg, mild cases of impetigo frequently undergo spontaneous cure in ten days or two weeks, while other cases tend to run on indefinitely. It is important before applying any medicament to the skin to **remove the crusts**, for it is manifestly impossible to bring the application into contact with micro-organisms which are securely protected by an overlying and impenetrable crust. The crusts are detached by washing with soap and water, after previously softening with oil or petrolatum. Mild **antiseptic remedies** are now applied to the skin.

Few cases are more amenable to suitable, or more rebellious to unsuitable, treatment than this very common disease. If the crusts are removed (either by **starch poulticing** or by **oil soaks**) and a weak antiseptic ointment (*hydrarg. ammoniat.*, gr. v—0.3 Gm.; *vaselin*, 3j—30 Gm.) constantly applied, even very extensive cases recover within a week or ten days. The secret of success is the thorough **removal of the crusts**, and the constant application of a **weak antiseptic**. Norman Walker (Monthly Cyclo., Oct., 1908).

It is desirable to rid the patient, particularly when an adult, of this conspicuous and disfiguring affection with the greatest possible expedition. One of the best methods is to frequently apply during the day the following lotion:—

℞ *Hydrargyri bichloridi* gr. j (0.065 Gm.).
Glycerini f3j (4 c.c.).
Spts. vini rectif. . f3j (30 c.c.).
Aquæ ... q. s. ad f3iv (120 c.c.).

and to supplement this with the nightly application of some such ointment as:—

℞ *Hydrargyri ammoniati* gr. x-xv (0.6-1 Gm.).
Pulv. amyli,
Pulv. zinci oxidi. of each 3ij (8 Gm.).
Petrolati 3ss (15 Gm.).

Sometimes lesions upon the face will yield more quickly to an ointment made up of:—

℞ *Resorcini* gr. xv (1 Gm.).
Lanolini,
Petrolati āā 3ss (15 Gm.).

Or, to a lotion of resorcin:—

℞ *Resorcini*,
Acidi borici āā gr. xl (2.6 Gm.).
Glycerini f3j (4 c.c.).
Alcoholis f3ss (15 c.c.).
Aquæ q. s. ad f3iv (120 c.c.).

When the patches are upon covered surfaces they may be painted twice a day with a 10- to 20- grain (0.6 to 1.3 Gm.) solution of *nitrate of silver*.

It is highly important to caution patients against touching the lesions, for by this means healthy areas of skin are inoculated. It is also desirable to avoid pillow infection at night by covering the affected parts, when possible, with a bandage.

Eruptions following impetigo contagiosa are frequently met with in children. They may occur sporadically or in epidemic form (especially in schools); lesions of impetigo may also be present. This is a degenerate form, or a sequel to impetigo, and is streptococcic in nature. It is easily cured with:—

℞ *Tannini*,
Calomelanos .āā 0.3 Gm. (5 grs.).
Petrolati 30 Gm. (1 oz.).

To be applied to the affected skin.

When the disease recurs, it may be due to associated impetigo lesions, which should be discovered and treated. In such cases a strong solution is required:—

℞ *Zinci sulphatis*.. 7 Gm. (1¼ drs.).
Cupri sulphatis.. 3 Gm. (¾ dr.).
Aq. camphoræ . 300 Gm. (10 oz.).

A tablespoonful to be added to the water used in washing the face.

When the skin is red, with the surface mummified, or slightly scaly, this condition is most frequently due to the abuse of soap on the face. The following is useful:—

℞ *Petrolati*,
Adipis lanæ,
Aquæ rosæ,
 āā 10 Gm. (2½ drs.).
Zinci oxidi 4 Gm. (1 dr.).

Apply once or twice daily.

Sabouraud (Jour. des sci. méd.; N. Y. Med. Jour., Nov. 30, 1907).

Case of impetigo contagiosa in which there was a scattered, crusted eruption of the face and neck. Both nostrils were intensely red, crusted, and discharging an acrid serum. Conjunctivitis of the right eye was also present. For the face and nostrils an ointment was ordered of the following composition:—

R *White precipitate*
ointment ℥iv (16 Gm.).
Zinc ointment ℥j (30 Gm.).

M.

Compresses of a hot, saturated solution of boric acid were directed to be used on the eye; also in the nostrils. The outer surface of the eyelid did not improve under this treatment and a paste of the following ingredients was applied:—

R *Starch*,
Zinc oxide .of each ℥j (4 Gm.).
Naphthalin ℥ij (8 Gm.).

M. Sig.: Use at night and wipe off with olive oil in the morning.

Under the application of this powder and the dusting of calomel in the eye three times a day the condition of the patient was improved. Montgomery (Jour. of Cutan. Dis., Sept., 1910).

The use of ordinary protective dressings is frequently a source of trouble in infants, as the little patients are rendered nervous thereby and prevented from sleeping. Furthermore, frequent changing is necessary if the dressings are to be kept clean, and this is difficult if the lesions are widespread. The following preparation is both effectual and convenient, in that no covering dressing is required:—

R *Fuchsin* gr. xv (1 Gm.).
Absolute alcohol ℥iiss (10 Gm.).
Phenol gr. lxxv (5 Gm.).
Distilled
water ℥iiiss (100 Gm.).

M. et ft. solutio.

In treating the skin lesions the superficial, friable part of the crusts

is first removed by means of compresses soaked in a zinc sulphate solution:—

R *Zinc sulphate*.. gr. xv (1 Gm.).
Distilled
water ℥vij (200 Gm.).

Fiat solutio.

Each projecting crust is then individually soaked, by direct pressure of cotton, with the fuchsin solution. The surrounding healthy skin should not be touched. Upon allowing the solution to dry on thoroughly, a red, glossy covering is formed, which is impervious to air. Daily applications are made, and in eight, six, or even three days the crusts will be observed to shrivel markedly, almost disappearing. When the last vestige has fallen off, the underlying lesion will heal under the fuchsin in twenty-four hours.

This measure may be used with similar success in ecthyma, in the presence of somewhat confluent and deep-seated crusts in varicella, in infected patches of pemphigus, and in various pyogenic skin infections, *e.g.*, those accompanying nasal or aural suppurative processes. H. Triboulet (N. Y. Med. Jour., from Nourrisson, Jan., 1913).

IMPETIGO HERPETIFORMIS.

DEFINITION.—This is a rare disease, occurring generally in puerperal women, and characterized by the appearance of miliary pustules disposed in clusters or annularly. It is generally fatal.

SYMPTOMS.—The lesions described above occur in successive crops and especially in the genitocrural region, the inner and posterior aspect of the thighs, though it may invade the whole body. Their development is accompanied by chills and a temperature which recall a septicemia or pyemia, with which the disease is closely associated. The tongue is dry and there is vomiting, diarrhea, albuminuria, delirium, and other symptoms of grave constitutional disturbances, which increase in severity, the patient dying from exhaustion.

ETIOLOGY.—The disease is evidently an infection of a septicemic type. Al-

though several organisms have been incriminated, the cause of the disease is still obscure.

TREATMENT.—Practically all cases reported, about 20 in number, have died. Those which survived were kept in **continuous bath**. Linsen recently reported a bona-fide case in which **serum from a pregnant woman** had been injected. S.

INCONTINENCE OF URINE.

See **ENURESIS**.

IMPOTENCE. — DEFINITION. —

Impotence, or impotency, signifies inability to carry out properly the sexual act, *i.e.*, to have sexual intercourse in a normal manner, whether actual inability to supply spermatozoa exists or not. Castration after puberty fails to abolish potency, except after considerable time. Intromission of the penis by virtue of its erect condition and a subsequent ejaculation of fluid are the 2 essential conditions of potency.

VARIETIES AND CAUSES.—True impotence is due to a physical deformity or disease, while *false* impotence is of psychic origin only. The former type is less common, and includes cases due to a sharply bent condition of the penis when erect, tumors of or near the penis, elephantiasis of the genitals, pronounced hypospadias or epispadias, tight urethral stricture causing dribbling of semen after subsidence of erection instead of ejaculation during erection, posteriorly directed ejaculatory ducts causing discharge of the semen into the bladder, abnormal or very small size or absence of the penis, a tight phimosis, and a hydrocele, ankylosis of the thigh near the abdomen, or excessive abdominal panniculus rendering the approximation necessary for intercourse impossible. True impotence may also be caused by organic disorders of the nervous system preventing erection or ejaculation or both, or by old age. A temporary true impotence may occur in the drunken state or chronic alcoholism, in drug habitués, from excessive use of tobacco, from marked lowering of vitality, and from continued sexual abuse. A eunuch is often impotent, but not necessarily so.

False impotence may even be merely an attitude of the mind. It may arise from some emotional shock, or be due to indifference toward the partner or to sexual perversion. Many cases are the result of incomplete or evanescent erection and premature ejaculation—a frequent consequence of excessive sexual excitation. In *nervous* impotence, the individual, though not lacking in sexual desire or energy, and in fact sexually hypersensitive, is unable to have a satisfactory erection in actual intercourse, the erection being inhibited by excessive excitement, the memory of a previous signal failure in coitus, perhaps the result of some external condition not under his control, or the fear of impotence *per se* engendered by the reading of quack advertisements. In some other instances, the impotence is imaginary, the subject being merely less powerful sexually than others with whom he compares himself.

TREATMENT.—In true impotence this consists in correction, in so far as possible, of the deformity, infection, intoxication, or other condition causing it. Where sexual excess or overexcitement is a factor, **rest of the function** for a time is indicated. To excite the sexual function, the measures available include an **ample diet, rich in phosphorus; cold baths; sea bathing; hot or cold affusions locally; counterirritation with mustard; general massage or rubbings with a brush, and excitant drugs.** **Strychnine** is of recognized value. **Phosphorus**, $\frac{1}{40}$ grain (0.0015 Gm.) a few hours before intercourse, later cautiously increased, directly increases sexual desire (Keyes). **Yohimbine, ergot, iron, and cannabis indica** have also been recommended. **Cantharis**, in doses of 5 to 8 minims (0.3 to 0.5 c.c.) or less of the tincture, with or without full doses of **nux vomica** and tincture of **ferric chloride**, is likely to prove useful in impotence resulting from sexual excess, but tends merely to excite erection without influencing sexual desire, and must be used with caution. In impotence due to organic impairment of the testicles, **testicular extract** is of service.

In nervous impotence the probable emotional cause of the condition should be ascertained, and the individual so reassured

and encouraged that full use of what sexual power is available will be favored. Wrong impressions should be corrected, and the exact sexual capacity inquired into, that he may be warned of the risk attending excessive activity, and relieved of disappointment, even after prolonged sexual rest. A stay in the country, preferably with plenty of **exercise** together with **tonics**, is often of value to eliminate former pernicious mental associations or habits and restore confidence.

The use of **anterior lobe pituitary body**, in 6 cases of impotence aged from 35 to 62 years, with more or less marked improvement, is reported by T. C. Stellwagen (N. Y. Med. Jour., Nov. 4, 1916), $2\frac{1}{2}$ to 5 grains (0.16 to 0.3 Gm.) being given 3 times daily, together with tonics, **prostatic massage**, and regulation of diet.

INDICANURIA. —DEFINITION.

—Indican, in small quantities, is a usual constituent of the urine; under certain circumstances, however, the amount is so large as to merit the designation of indicanuria.

SYMPTOMS.—Normal urine contains very small quantities of indican; about 0.0045 to 0.0195 Gm. is excreted in twenty-four hours; different animals secrete much more, horses about twenty times as much. Urine containing much indican is dark-colored, brown to black; in rare cases indigo is deposited as a blue powder.

The presence of indican in excess in the urine is demonstrated by different tests.

Heller's Test.—By the addition of nitric acid a blue-violet ring is formed at the line of contact of acid and urine.

Jaffé's Test.—Equal volumes of urine and hydrochloric acid are mixed in a test-tube; a few drops of a solution of sodium hypochlorite are added and the mixture is shaken. The blue color of indigo will then appear. Stokvis proposes to add some drops of chloroform, in which the indigo dissolves.

Senator's modified Jaffé's test is applied as follows: Ten to 15 cm. of urine are mixed with an equal quantity of concentrated hydrochloric acid; 3 to 5 c.c. of chloroform and 1 drop of saturated solution of chlorinated lime are added and the

mixture is shaken. The chloroform is colored blue when indican is present in excess.

Daland's Test.—To 10 c.c. of filtered urine add 1 drop of a 1 per cent. solution of potassium chlorate, then 5 c.c. of chloroform, and lastly 10 c.c. of pure fuming hydrochloric acid (sp. gr., 1.19). It is needful to add the reagents in the order named, and to mix the contents of the test-tube by repeatedly pouring the contents from one test-tube into another. If the contents of the test-tube be now permitted to settle, the chloroform will be found at the bottom, colored blue with the indigo, and after some time the indigo will crystallize out in small cubes with rounded corners. If the whole of the twenty-four hours' urine has been used, and the amount of the indican is at all considerable, the amount of indigo may well be ponderable: in one case, by no means a bad one at that, 23 mg. of indigo was thus obtained, as the equivalent for the twenty-four hours' indican excretion.

Holland's Test.—J. W. Holland uses the following method: To a test-tube one-quarter filled with urine he adds the same amount of concentrated hydrochloric acid to liberate the urinary indican, and then, as oxidizer, a piece of sodium perborate as large as a pea; he then gently agitates the effervescing mixture to dissolve it. If the amount of indican is large the urine turns faintly blue. To concentrate the color 1 c.c. of chloroform is added; the tube is then closed with the thumb and gently shaken at least two minutes. The chloroform separates as a layer at the bottom, varying in blueness according to the proportion of indican. If the patient is taking iodide of potash, the violet blue of free iodine may cause a fallacy; and if such is suspected, pour off the acid fluid and add potassium hydroxide to the chloroform, when the color due to iodine will disappear and the indigo blue remain. With this test he has uniformly obtained a distinct indigo-blue reaction in the presence of from 1 to 5 mg. indoxyl salts per liter.

Obermayer's Test.—The urine is precipitated by the addition of a solution of acetate of lead; the filtrate is treated by the addition of concentrated hydrochloric

acid and a few drops of a 2 to 4 per 1000 solution of perchloride of iron; the mixture is shaken with chloroform.

Askenstedt has evolved (1912) from the Obermayer test a modification which, though still possessing certain imperfections, yet combines the advantages of the ordinary quantitative tests for indican with a greatly simplified technique, rendering it the one best adapted to the requirements and limitations of the medical practitioner. The test is carried out as follows: To 10 c.c. of urine in a test-tube add 10 c.c. of the ferric chloride solution and mix by inverting the tube once; then add quickly 8 c.c. of chloroform, and extract the indigo in formation by shaking the tube 400 times, holding it in a horizontal position. After this let the chloroform fall to the bottom of the tube, then pour off most of the supernatant fluid, fill the tube nearly full with water, invert it a few times to wash the chloroform, and let this again precipitate in the tube, and pour off most of the water. Repeat twice this process of washing, taking care that no chloroform escapes with the wash water, and allowing not more than 2 or 3 c.c. of the last wash water to remain over the chloroform. Now add from 13 to 15 c.c. of alcohol and mix by shaking. A clear blue fluid should result. If hazy, add 1 or 2 c.c. more of alcohol until the fluid clears up. Compare the color of this fluid with an equal quantity of a standard solution of indigo blue in the second test-tube by holding the 2 test-tubes in front of a white surface. This standard solution is made by pouring into the empty second tube a quantity of water equal to the amount of the fluid in the first tube, and then dropping the stock solution of indigo blue into the water, inverting the tube after each drop, until both solutions have the same amount of blue color. If this requires 4 drops of the stock solution the percentage is 0.0004; if 5 drops, 0.0005; if 6 drops, 0.0006, etc.

The indican extract will often prove slightly greenish. By adding one or more drops of the picric acid solution to the standard solution in the test-tube, this can be made to conform to the color of the extract. Albumin or bile in the urine will not interfere with the estimation;

sugar reduces it. To compensate for indican not collected by the chloroform and the small amount lost in the washings, add 20 per cent. to the final result. Urine containing 0.002 per cent. or more of indican, or giving a blackish extract, should be diluted with equal quantity of water and retested.

Quantitative tests have been indicated by Jaffé and Salkowski, advantage being taken of the bleaching powers of hypochlorite of calcium, a standard red solution of this salt being used to effect the complete decoloration of the indigo.

Barberio's Test.—Barberio uses sulphurous acid, in the form of sodium sulphite dissolved in distilled water in the proportion of 1:2000. To 5 c.c. of filtered urine, a few drops of this solution are added, the mixture shaken, and then mixed with 5 c.c. strong HCl and 2 c.c. chloroform. The chloroform takes on a blue color, whose intensity depends, in the absence of iodine, upon the amount of indican in the urine. If iodine is present, the addition of a crystal of sodium thiosulphate suffices to decolorize it.

ETIOLOGY.—By the decomposition of proteids indol is formed, which is absorbed in the intestine and oxidized in the blood, forming indoxyl.

Indicanuria is one of the most important conditions in connection with clinical medicine. Indican was discovered by Prout, in 1840, and blue substances have been recorded in the urine from the time of Hippocrates to the present. Baumann and Breiger were the first to determine accurately the composition of indican. Baeyer demonstrated that a more simple substance, indol, was the antecedent of the more complex body known as indican. Nencki and others demonstrated beyond a question of doubt that indican is always the result of putrefactive fermentation. Animal proteids are more likely to undergo putrefactive fermentation than the vegetable class. Vegetable proteids are much more difficult of digestion than are the animal class; hence they are less economic, and often detrimental to the system.

Senator has proved conclusively that bacterial action is required to produce putrefactive fermentation in connection with the production of indican. The sulphur atom in connection with the formation of indoxyl potassium sulphate comes from the proteid molecule as the result of its oxidation reduction. Indican is primarily formed in the intestinal tract, and not in the liver. Numerous toxins are formed at the same time that the indican is produced. These toxins are absorbed into the circulation from the alimentary tract, and by their action upon the nervous system excite an almost endless variety of symptoms.

The conditions favoring the production of indican are errors in diet, lack of outdoor exercise, defective digestive secretions, and profound disturbances in the working of the nervous mechanism. Indican in the urine is never normal, but always indicates an abnormal condition, because a putrefactive process can never be regarded as a normal or physiological phenomenon. W. H. Porter (Med. Rec., June 15, 1907).

Clinical significance of indicanuria, based on 10,000 examinations for indican by the Jaffé test. True cases of intestinal intoxication are rare. It does not occur from the putrefactive substances in the bowel directly, but from their entrance into the blood. We may have many toxins in the stools without its occurrence, and excessive amounts of indican in the feces without showing any indican in the urine. A special study of patients operated on shows that trauma to the intestinal wall is sufficient to produce indican if sufficiently prolonged and severe, whether it occurs through mechanical injury in operation, adhesions, or coprostasis. Enteroptosis may produce it and exaggerated intestinal putrefaction with its consequences. The constant finding of indican in constipation complicated with cardiac insufficiency is notable.

Indican exists only in extreme

hepatic insufficiency and in gastric hyperacidity, especially with gastric and duodenal ulcers. In several cases of ozena and dental caries indicanuria was conspicuous, though there were other signs of pathological conditions. The patients evidently swallowed more or less virulent pus in their sleep, which furnished the source of intestinal infection and putrefaction, the stomach being empty and not containing any hydrochloric acid. The insufficiency of pancreatic juice, with its consecutive increase of intestinal putrefaction, was shown in 2 cases of carcinoma of the pancreas with ever-present indican. Bile insufficiency as a cause of indicanuria was not proven by the author's studies. About 50 cases of icterus with complete occlusion of the common duct showed indicanuria in only 10 cases. In 3 of these there was drainage through a cholecystotomy, with absolutely acholic stools. A. Baar (Jour. Amer. Med. Assoc., Nov. 5, 1910).

When excreted in the urine it is combined with sulphuric acid and excreted as indoxylsulphuric potassium-indican. This salt may be isolated as rhomboid, white crystals, which are soluble in water and hot alcohol, hardly soluble in cold alcohol and not at all in ether; by heating it with hydrochloric acid it is divided into sulphuric acid and indoxyl, which in presence of oxidizing substances gives indigo. By fermentation of urine containing much indican, indigo is also formed.

Indicanuria is ordinarily dependent on decomposition of the intestinal contents consequent upon constipation or occlusion of the intestinal tract, *especially of the small intestine*, while occlusion of the large intestine does not cause it.

Urinary indican is a product of intestinal putrefaction. There may be putrefaction without the production of indol, but there cannot be indicanuria without putrefaction. A maximum excretion of indican, that is, an amount which on Folin's scale gives an index of 100 or over, may be safely relied on to indicate excessive intestinal putrefaction, and espe-

cially the intoxication arising therefrom. A maximum reaction which gives an index under 100 may be significant, but its interpretation should be strictly guarded by the general condition of the patient, that is, by the oxidizing and excretory capacity. A heavy indican reaction which markedly subsides under treatment undoubtedly indicates a lessening intoxication, but minor variations in the color index have no significance at present. No interpretation can be placed on a negative reaction, too many unsolved factors entering into the problem. Houghton (Amer. Jour. Med. Sci., April, 1908).

In the conditions of hunger the albuminous secretions of the bowels are decomposed and form indol; newly born infants do not produce indol, because their intestines do not contain bacteria.

Indican is found in cases of decomposition of pus, as in putrid empyema, putrid suppurations, etc.

Some persons are resistant to the poisons of which this reaction is an indication. Conversely, there are, no doubt, individuals who are particularly susceptible, and react violently to the poisons generated by autointoxication. This reaction may occur in the form of various cutaneous diseases, as an erythematous, vesicular, papular, or bullous condition. Engman (Jour. of Cutan. Dis., April, 1907).

It has also been observed in different diseases, especially of the stomach and the bowels: carcinoma of the stomach, gastric ulcer, acute and chronic gastric catarrh, cholerae nostras and Asiatica, peritonitis, etc.

In the 2092 cases which form the basis of the writer's monograph on indicanuria, cases *with* constipation showed a positive indican test 736 times, and a negative test 820 times, while those *without* constipation showed positive tests 2600 times, a negative test 2503 times. This means that the non-constipated patients showed indicanuria much oftener than the constipated ones.

Another familiar claim as to etiology of indicanuria was the statement that abnormal quantities of indol in the feces, produced by abnormal putrefaction, cause the excretion of indican in the urine. But there certainly is no necessary relation between indicanuria and fecal indol, for the investigation showed that the feces contained indol, while the urine showed no indican and *vice versa*. This fact proves that it is not alone the quantity of nitrogenous putrefactive substances within the intestinal tract which causes indicanuria, and that there must be some other reason for the entrance of this material into the circulation besides the mere overproduction of the same within the intestinal tract. The writer found in many cases of diarrhea, which represent the attempt of the organism to rid itself of the enterogenous putrefactive substances, excessive indol in the feces and no indican in the urine.

As to the practical results of the study: Instead of guessing as to the diagnosis in those cases which come under observation with definite gastrointestinal symptoms, the twenty-four-hour urine should be regularly tested for indican and, after having made 20 or 30 such tests, we should, with due consideration of all other clinical symptoms, be able to make a diagnosis. One single test has no value at all and it is only the repeated examination of the urine for indican which will throw additional light on those obscure lesions of the gastrointestinal tract which for years may not show any definite symptoms.

If these tests are made, the indicanuria cases may be divided into three types: 1. Transitory, due to some transitory anatomical lesions or temporary insufficiency of gastrointestinal secretions (psychic). 2. Constant, due to permanent or progressive anatomical lesions of the gastrointestinal tract, or to permanent insufficiency of the gastrointestinal secretions (earmarks of hypoplastic constitutional anomaly). In these

INDICANURIA AS DIAGNOSTIC SIGN. (WILLIAM H. PORTER.)

Test.—Place in a test-tube equal quantities (10 c.c. of each) of urine and chemically pure concentrated hydrochloric acid. To this mixture add 3 drops of a $\frac{1}{2}$ per cent. solution of potassium permanganate. Then add a small portion of chloroform, 1 or 2 more drops of the permanganate solution, and a few drops more of chloroform, or a total of 5 c.c. of chloroform, and shake vigorously for a few seconds. Compare results with opposite color scale.

Fig. 1.—In the **absence of either extrinsic or intrinsic putrefaction** the chloroform will settle to the bottom of the fluid in the test-tube and remain pure white. This indicates a perfectly normal state.

Fig. 2.—If there is a **simple putrefactive process** of either form with little or no toxic infection, but in which the indoxyl potassium sulphate has found its way into the urine, there will be formed first, upon addition of the acid and permanganate solutions, a purplish cloud in the fluid in the test-tube. Upon addition of the chloroform the purple quickly gives place to a decided deep indigo blue. This is due to a precipitation of small particles of indigo blue resulting from the oxidation of indoxyl potassium sulphate into the substance called indigo and its precipitation by the chloroform. In the absence of all other pigments and toxic products the deposited chloroform and indican remain deep blue in color. This result is indicative of simple indicanuria.

Figs. 3 and 4.—When **pronounced toxemia is associated with the putrefactive process**, there is often a breaking-up of the hemoglobin and the formation of a red pigment; or, there may be some occlusion to the internal ends of the bile-ducts. When this is the case the bile-pigments, acids, and salts re-enter the blood and finally the urine. Various toxins also enter the urine. When this is the case the pigments or toxins interfere with this test reaction as just described; that is to say, these substances are added to or precipitated with the indigo produced by the oxidation reduction of the indoxyl potassium sulphate. Now, instead of the sharp and distinct blue reaction, a dirty blue, purplish, or reddish color is obtained, the shading depending in a large measure upon the form of pigment or toxin entering into the combination. This result indicates a more or less complex toxemia in addition to the simple indicanuria.

Fig. 5.—With a more **marked change in the hepatic cells** and the development of a somewhat pronounced occlusion of the internal ends of the bile-ducts, varying shades of green will be noticed in the deposited chloroform. This always indicates that a considerable amount of the bile-pigments, acids, and salts has re-entered the blood and been excreted with the urine. This is especially so in reference to the biliverdin.

Fig. 6.—With a **still more pronounced hepatic involvement** the color will be a still more pronounced green.

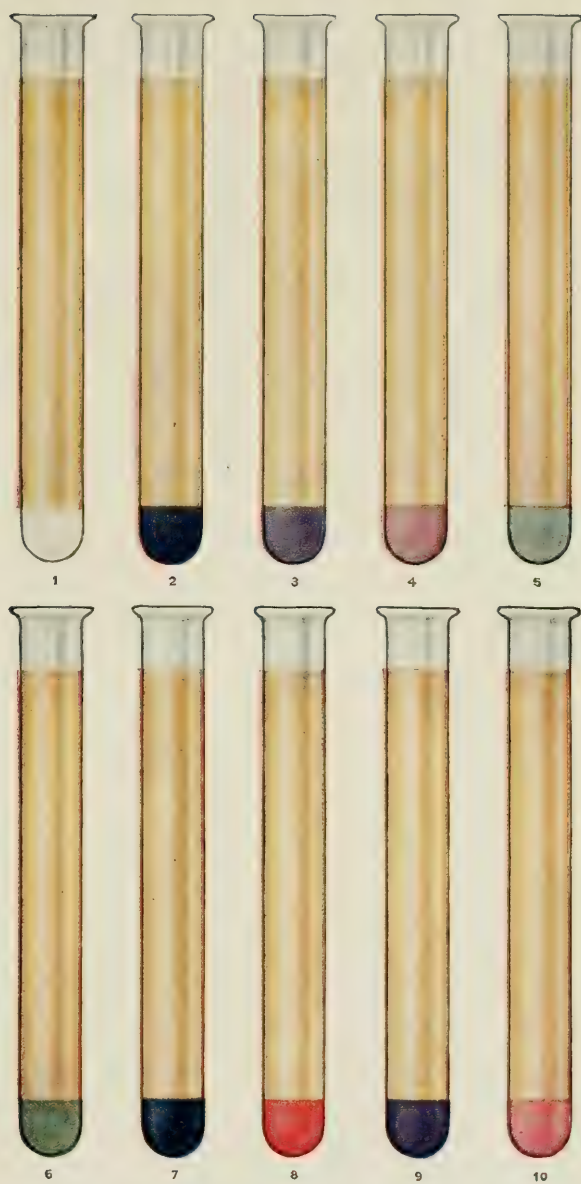
Fig. 7.—When the involvement of the liver is still greater the reaction will be still more green or it may assume deep green or bluish black. Where the **putrefactive process and the liver involvement are both very pronounced**, the deposited chloroform will be almost black.

Fig. 8.—When iodides are being taken by the patient and **there is no putrefactive fermentation**, the deposited chloroform instead of being white, as under normal circumstances, is cherry red.

Fig. 9.—If in conjunction with the use of the iodides by the patient, there is also **pronounced putrefactive action**, the deposited chloroform will be decidedly violet.

Fig. 10.—If the **putrefactive process is less intense**, the deposited chloroform will assume a more pink color.

The shade of color in the last two reactions, as in all the other tests, is governed largely by the amount and variety of the extraneous pigments added to the indigo.



Indican color scale. (*W. H. Porter.*)
Post-Graduate.

latter cases—about 1½ per cent. of all—indicanuria and many of the clinical symptoms can be removed by high **colonic lavage**. 3. Recurrent, due to some recurrent anatomical lesion of the gastrointestinal tract. High colonic lavage will remove this type of indicanuria only when the lesion is located in the colon; if the lesion be higher up, however, high colonic lavage will have no influence whatever. Indicanuria in these cases is quite often the only positive evidence of gastrointestinal lesions which require surgical interference (chronic appendicitis, cholecystitis, ulcer of the duodenum or stomach). G. Baar (Northwest Medicine, July, 1913).

Indican has been recognized as a symptom of tuberculosis.

It must, nevertheless, be borne in mind that ingestion of large quantities of nitrogenous food is apt to lead to indicanuria even if no derangement of the digestion be present.

On account of the difficulty of obtaining the total 24 hours' urine of infants the writer had to be content with specimens collected at different hours. There is probably not as much difference between the day and night urine of infants as later in life. Of the 18 infants whose urine was systematically examined, 12 were less than a year and the oldest was only 17 months old. The children fed on cow's milk had a much larger indican and ethereal sulphates content than the breast fed, and the dyspeptic children had much more than the healthy children. The maximum was found in the children of the alimentary decomposition type, and those with grave digestive disturbances. Not a trace of either indican or ethereal sulphates was found in the healthy breast fed infants. L. Maccone (Rivista di Clin. Pediat., Jan., 1919).

In different diseases of the nervous system, especially after epileptic fits, an abnormal quantity of indican has been noticed in the urine.

In chronic cystitis indican may be de-

composed in the bladder and indigo deposited from the urine as a blue powder.

TREATMENT.—According to Eason, it is essential in most cases to restrict the amount of proteid, the rigor with which this is to be observed depending on the severity of the condition. The rules for mastication as formulated by Horace Fletcher are also of much importance. Hygienic and proper exercise in the open air is of great importance in aiding metabolism, increasing elimination and strengthening the digestive functions.

Patients fail to do as well as expected when treated medicinally. It is hardly advisable to use drugs for protracted periods, as the usefulness of the protective members of the intestinal flora may be harmfully influenced.

Lavage of the colon and stomach may sometimes prove necessary.

Sour milk is an important remedy in this connection. Rovighi drank daily a liter and a half (3 pints) of milk subjected to lactic acid alcoholic fermentation. In a few days the products of intestinal putrefaction in his urine were greatly reduced. Herter reduced the amount of indican in dogs by injecting pure cultures of lactic acid bacilli into the small intestines. These and other observations explain why sour milk is of such value as a medicine, and why lactic acid will control certain cases of infantile diarrhea. Mackee holds that sour milk will control the majority of cases of indicarnuria.

Metchnikoff believed that sour milk was of benefit not alone in virtue of its lactic acid, but also on account of the large number of desirable bacteria contained therein, which are able to colonize in the intestines, but Herter's work tended to disprove this view. Mackee found that although lactic acid will control indicanuria to some extent the indican will return to its original degree very soon after the lactic acid is discontinued. **Buttermilk** and **milk soured by native bacteria** have more thorough and more enduring favorable effects. Even better results are obtained if milk be fermented by certain foreign bacteria. When employing such preparations as the **lactobacillin tablets**, the **lactone**, or **yoghurt capsules**, it should be remembered that we are only giving

relatively small numbers of bacteria, and they must be given over an extended period of time and combined with a favorable diet before their effects become clearly manifest. Pure cultures are especially convenient for those individuals who cannot tolerate sour milk, but the results are not so striking.

The ordinary antiseptics are useless. Large doses, or frequently repeated small doses, of **calomel** for the inhibition of the action of the pathogenic micro-organisms in the alimentary tract, also **tannalbin**, **balsam copaiba**, and **aspirin** have been recommended. The tannalbin acts largely by precipitating the thick, tenacious mucus so abundant in the alimentary tract. The balsam and aspirin are given in **fel bovis inspissatum** and **pancreatic extract** and the use of 1 per cent. **ichthyol irrigations** carried high up in the colon are said to have given good results. L. and S.

INDICANEMIA.—According to Tchertkoff (*Revue Méd. de la Suisse Romande*, Aug., 1917) indican in the blood is a sign of grave incompetency on the part of the kidneys. The technique he describes for estimation of the indicanemia reveals it only when it is within a pathologic range: to 8 or 10 c.c. of serum (obtained fasting by wet cupping or puncture of a vein), he adds an equal quantity of 20 per cent. trichloroacetic acid, and filters. Then, to 10 c.c. of the filtrate he adds an equal quantity of concentrated hydrochloric acid containing 5 mg. of ferric chloride to the liter. The whole is agitated, and then 3 c.c. of chloroform is added. After having agitated it several times in the course of fifteen minutes, he examines for the color reaction. The chloroform changes to a light or dark blue according to the proportion of indican in the serum. If there is no indican, the chloroform has no color. If there is iodine in the serum, the chloroform turns pink or a pinkish violet. This technique is reliable also for detection of iodine in the serum, but as this may interfere with the indican reaction, no iodine should be given the patient before the test. In his examination of 300 serums, indicanemia was invariably found when the azotemia reached nearly 1.5 Gm. to the liter, but it sometimes disappeared before

the latter—a favorable sign. It persists to the end in the fatal cases. Experimental research confirmed these clinical findings. There may be indicanemia with slight uremia, but the prognosis should be based on the persistence of the former. He thinks there is no need for quantitative estimation of the indican; the fact that it is within pathologic range is enough. The range shown by the technique described is about 2.5 mg. Any amounts above this show merely that the production of indican is large; they reveal nothing beyond the fact of renal incompetency already shown by the 2.5 mg.

In a study of the retention of indican in the tissues, Becher (*Deut. Archiv f. klin. Med.*, Apr. 29, 1919) finds that, contrary to nitrogen retention, no indican is found in the tissues when the kidneys functionate physiologically. When, however, incapacity of the kidneys occurs, retention of indican is evident. He found the larger proportion in the blood, and but very small amounts in the tissues. Del Pont (*Semana Med.*, May 20, 1920) comments upon the remarkable prevalence of indicanuria at Buenos Aires and is inclined to ascribe it to the bad condition of certain articles of food, with refrigerated meats as probable direct factor in the process—a factor which also must influence indicanemia.

INFANT FEEDING AND NURSING. See **NURSING AND ARTIFICIAL FEEDING.**

INFANTILE PARALYSIS. See **SPINAL CORD, DISEASES OF.**

INFANTILE SCORBUTUS.—**DEFINITION.**—A constitutional nutritional disease identical with scurvy of adult life, but occurring chiefly in infancy. Its principal features are pain on movement of the limbs, swelling in the course of the long bones, and a spongy, purple swelling of the gums.

An early diagnosis of infantile scorbutus is important. The picture of the affection, as outlined in the

textbooks, is one which applies to cases in which the disease has gained full headway; the patient has suffered for some length of time and has developed the full symptomatology of the disease. Koplik (*Archives of Diag.*, Jan., 1909).

Although scurvy is often associated with rickets, there appears to be no necessary connection between them, except that allied causes may produce them. Many of the older cases were described under the title of "Acute Rickets."

SYMPTOMS.—Anemia, irritability, and loss of appetite may occur as premonitory symptoms, but the first characteristic manifestation is pain in the limbs, usually the lower extremities. This may develop so suddenly that the parents are disposed to attribute it to an accident of some kind. The pain and tenderness on passive movement are at first intermittent, but soon become more constant, and the child holds the legs as though they were paralyzed, and screams on the slightest movement of them. The condition, in fact, amounts to a pseudoparalysis. In other instances the pain is limited to the arms.

As shown by about 60 cases of the disease, the more definite symptoms of scurvy are always preceded by a period of loss of appetite, slightly disturbed digestion or irritability and malaise. These are accompanied, or soon followed, by pallor and failure to gain in weight. After a period of a few weeks, or sometimes months, more characteristic symptoms appear. In one-half of the writer's cases the earliest symptom noted was tenderness on handling. Swelling or discoloration of the gums was the first symptom in about one-fourth, and hematuria in nearly as many more. In other cases paralysis, swelling of an extremity or ecchymoses were the first signs

noted. J. L. Morse (*L. I. Med. Jour.*, Nov., 1907).

Subacute and latent forms of infantile scurvy are very common among artificially fed infants in the larger cities where the whole milk supply is pasteurized. In latent scurvy the diagnosis rests largely upon prompt gain in weight and general improvement following addition of orange juice to the diet. To prevent these forms of scurvy in babies fed mainly upon pasteurized milk, **orange juice**, should be begun when the infant is a month old with a dose of a teaspoonful daily, to be increased so that at three months a tablespoonful is taken. A. F. Hess (*Jour. Amer. Med. Assoc.*, Jan. 27, 1917).

At about the same time, or a little later, there develops a deep bluish-purple, spongy swelling of the mucous membrane of the gums, generally over the upper incisor teeth. This may be so marked that the teeth become concealed. In most cases the involvement of the gums occurs only in infants whose incisor teeth have already erupted, but this is not necessarily the case.

Case of infantile scurvy in a child 13 months old which had been diagnosed as articular rheumatism. There was marked tenderness over the joints, and its sudden onset, with the inability of the patient to stand, made it resemble a form of infantile paralysis. When such symptoms are associated with bleeding gums, purplish, spongy swellings, and the bluish-black, subcutaneous hemorrhages visible on the inside of the cheek, the diagnosis of pseudoparalysis associated with scorbutus must be made. L. Fischer (*Jour. Amer. Med. Assoc.*, Jan. 25, 1913).

Together with the painfulness of the limbs, swelling in the shaft of the long bones can often be found. It is usually near a joint, but does not involve it. The soft tissues in the

affected situation are swollen, shining, but usually not reddened. Not infrequently, however, ecchymoses or petechiæ are found here or elsewhere. Orbital hemorrhage occurs in a small proportion of cases, producing a very characteristic exophthalmos. Hemorrhage from the kidneys is a common symptom, although usually of a nature discoverable only on microscopic examination.

Case in which there was extensive edema; no part of the body seemed exempt. The infant, aged 9 months, had a pallid, waxy appearance; although it looked as if the skin would easily pit on pressure, it was practically impossible to obtain a permanent indentation with the fingers. Pritchard (*Lancet*, June 7, 1913).

The general condition of the child suffers, and anemia is progressive, accompanied by wasting. There is a cachectic appearance, and one expressive of constant pain.

In a personal case the blood-picture showed hemoglobin, 40 per cent.; erythrocytes, 800,000; leucocytes, 12,000; polymorphonuclear cells, 40 per cent.; lymphocytes, 60 per cent.; eosinophiles, 1 per cent. Many megaloblasts, normoblasts, and transitional forms were found. In four weeks, under antiscorbutic treatment, the blood-picture was almost normal, the cartilage changes almost gone and the child fairly recovered. F. Glasier (*Berl. klin. Woch.*, i, 200, 1913).

The writer comments on the increasing frequency with which Barlow's disease is being encountered, on account of the widespread use of prepared foods, fresh milk having become too expensive for the poorer classes. In 1 of the author's recent cases, a 4 months' child was being given but 8 ounces of milk a day. It lost weight, became very pale, and suddenly grew extremely feeble, lying motionless with the legs partly flexed,

and very sensitive to movement. The left thigh was somewhat larger than the right. Complete recovery occurred under **increased feeding** and **orange juice**, $\frac{1}{2}$ ounce 4 times a day. The fact should be borne in mind that there are often encountered "fruste" forms of the disease, without bony or epiphyseal deformities or swelling of the gums. Thus, in 1 case there was noted weakness, apparent anemia, marked feebleness of the legs simulating paralysis, neuritis or acute poliomyelitis, and pain upon the least movement, suggesting arthritis and, in particular, joint tuberculosis. In another fruste case, the symptoms comprised merely swelling, softening, ulceration, and bleeding from the gums. Errors of diagnosis have been frequent in relation to this disease. Albert Jobin (*Bull. méd. de Québec*, Apr., 1919).

COMPLICATIONS.—Rickets is the most frequent of these, present in certainly over 50 per cent. of cases. Bronchopneumonia and gastroenteritis are not uncommon complications.

DIAGNOSIS.—Although the disease is usually easily recognized, many errors are made, because the possibility of scurvy does not occur to the physician. The diagnosis rests upon the great pain and tenderness of the limbs, and the tendency to hemorrhage into the skin and the gums. The disease is often mistaken for rheumatism. This affection, however, is of extreme rarity in infancy, and exhibits swelling of the joints rather than of the shafts of the bones. The epiphysitis of syphilis suggests scurvy in some instances. It, however, occurs generally at an earlier age, is less tender on movement, and is oftener limited to the arms. The lesion, too, is always situated at the epiphysial junction, and not in the shaft of the bone. The pseudoparal-

ysis of scurvy bears some resemblance to poliomyelitis. There is, however, in the latter disease far more tenderness combined with an alteration of the electric reactions. Osteomyelitis invades the joints and is attended by fever and symptoms of pyemia. The frequent complication of scurvy by rachitis is often the cause of the overlooking of the former disease. In rickets, however, there is no hemorrhagic tendency, and improvement under treatment is slow.

ETIOLOGY.—Nearly all the cases occur in the first two years of life, and the majority of these in the latter half of the first year. Sex and season appear to have no etiological influence, but there is a distinct tendency to greater prevalence in some countries than in others, which cannot be attributed to greater fault in the method of feeding the infants.

Within one year the writer saw 2 cases of infantile scurvy, and has had another reported to him, following the use of sterilized modified milk in an endeavor to give the baby milk which was safe for its consumption. Babies can do well on sterilized milk for a reasonable length of time; but if this is kept up too long, scurvy develops. Those superintending the feeding of babies should see to it that the milk is not too thoroughly sterilized during the winter months, when much of the milk is comparatively safe. In the spring, when called to infants who have lived for several months on modified milk, sterilized or pasteurized, and who are suffering from what the mothers call "rheumatism of the legs," with evidence of subperiosteal hemorrhage or spongy gums, scurvy should be thought of. Editorial (Jour. Mich. State Med. Soc., Nov., 1912).

The writer observed 45 cases of scurvy in infants at Paris. None of

them had been getting breast milk or fresh milk or even simply boiled milk; all had been fed with sterilized flour foods. Signs of rachitis were present in nearly every case. The artificial feeding is responsible for both. If the milk is sterilized—dead milk—there may be both scurvy and rachitis; if the food is fresh—living milk—the child is exposed to danger of rachitis alone. J. Comby (*Arch de Méd. des Enfants*, July, 1917).

Good hygiene and favorable social conditions rather predispose to the disease than the reverse. The active cause is certainly the employment of a diet unsuitable for the child, although it is uncertain just what the nature of the unsuitability is. It would seem that some element is lacking which is necessary to the health of the infant, and that this varies with the case. Certainly the majority of infants with scurvy have been fed upon some proprietary food. It is probable, too, that the sterilizing of milk has an unfavorable influence in certain cases. Yet, in addition, there must exist some individual predisposition, otherwise all children fed in this way would suffer from the disease.

Series of cases of Barlow's disease occurring in children who were kept for some time on milk furnished by the city of Bonn. Symptoms consisted of diminution of appetite, pallor, pain upon being lifted or touched, swelling and deformity of the thighs, bleeding from the gums, ecchymoses, hemorrhage into the cellular tissues about eyes, and hematuria. The blood picture showed an excessive hemoglobinemia, some oligocythemia, poikilocytes, macrocytes, normoblasts, polychromatophilia, and basophilic granules within the red corpuscles. The milk given the children was sterilized for ten minutes at 102° C., the steam passing through under a pressure of 1½

atmospheres; the process now simply consists of steam at from 98° to 100° passing through for three minutes. The cause of the disease according to Barlow is too long sterilization, as it produces certain toxic substances at the expense of some of the food molecules. All of the patients recovered as soon as antiscorbutic treatment was ordered and the sterilized milk replaced by **raw milk**. Recovery resulted promptly in a child in which the hemoglobin had fallen to 20 per cent. Esser (Amer. Jour. Med. Sci., from Münch. med. Woch., Bd. iv, S. 896, 1908).

The steadily increasing use of artificial foods seems to be increasing the prevalence of scorbutus in infants. In 8 personal cases all were in well-to-do families, the children of the poor not being fed on these expensive artificial foods and usually are given early a little food from the family table. Incomplete forms of scorbutus are more frequent than is generally recognized; he knew of a number of instances in which the infants were treated for Pott's disease, coxalgia, or osteomyelitis. Hutinel warns that scorbutus should be thought of first in every case of painful paraplegia in an infant, or even when the child is merely a little uneasy when its legs are touched. De Sagher (Annales de méd. et chir. infant., March 15, 1913).

PATHOLOGICAL ANATOMY.—

The principal lesions are those of the bones, combined with a tendency to hemorrhage in various other regions. The bone-marrow is replaced by embryonic connective tissue. There is an arrest also in the formation of bone from the osteoblasts. Hemorrhage is always found beneath the periosteum, but frequently elsewhere as well; as into the muscles and skin; the serous or mucous membranes, or in the internal organs.

The nitrogen metabolism in Barlow's disease shows no variation

from the normal. The total ash metabolism is also normal except in the period of convalescence, when there is a diminished calcium retention. This observation agrees with the pathological and Röntgen findings in Barlow's disease, which show an increased amount of calcium in the osseous system during the height of this disease, which disappears when the signs of the disease also disappear. Lust and Kloeman (Jahrbuch f. Kinderheilkunde, June, 1912).

PROGNOSIS.—The disease runs a chronic course with little tendency to improvement, and death is liable to occur in severe cases unless treatment is instituted. Under appropriate treatment, however, recovery is remarkably rapid.

TREATMENT.—The abandoning of proprietary food, and sometimes the changing from a cooked milk mixture to one of **raw milk** should be done unless there is a contraindication. Sometimes, however, for other reasons, a change in diet is not advisable.

Infantile scorbutus is entirely due to improper feeding. Condensed milk, sterilized milk, and so on, are often found to have been the cause. Milk, however, has little tendency to produce scorbutus if simply heated *short of boiling* before being used. When children are fed on articles of diet liable to produce scorbutus, these must be supplemented by antiscorbutic substances, such as raw meat or **orange-** or **grape- juice**. Meat-juices of the manufactured kinds are useless for this purpose. What is needed is **fresh raw-meat juice**.

When fruit-juice has no effect, then it has been given in too small a quantity. Potatoes have antiscorbutic properties, but they are not so suitable in such cases as a prophylactic remedy. The juice of fruit, moreover, can be given over a longer period without producing any diges-



Bone lesions in infantile scorbutus.

tive disturbance. Hill (Brit. Med. Jour., July 28, 1906).

In 7 cases of infantile scurvy the infants were taking, respectively, sterilized milk, pasteurized milk, milk that was not heated when made, but overheated when warmed for the bottle feeding, pasteurized peptonized milk, a weak milk mixture made up with starchy food, with heated milk. In treating this disease the cause must be removed. Devitalized food should be discontinued, and we should substitute **fresh milk, fruit-juice, beef-juice, raw egg albumin, and purée of potato**. Sterilized milk may be desirable under certain conditions, but better is **fresh cows' milk** which is produced under ideal hygienic conditions. La Fetra (Amer. Jour. Med. Sci., June, 1907).

The specific treatment for the disease is the administration of **fresh fruit-juices**. Of these **orange-juice** is one of the best, the juice of half an orange, and later of a whole orange, being given daily. The presence of diarrhea is no contraindication.

The administration of **fruit-juices** is as prompt in its effect as quinine in malaria. **Orange-juice** is the best of the fruit-juices and can be given in doses of 1 tablespoonful or more every two hours. Rotch recommends the juice of one orange in twenty-four hours; this may be diluted one-third with water. **Grape-juice** comes next in value, while **lemon-juice** is considered objectionable because of its great acidity. Comby, Still, and others give **mashed potatoes** or **potato soup** besides the orange-juice, while Baginsky and other German observers report good results from **fresh brewers' yeast**. Wright has recently advised the administration of **sodium lactate**. **Iron, arsenic, and codliver oil** may be given late in the disease where there is marked secondary anemia or exhaustion.

Rest is essential, with as little handling of the child as possible on account of the pain and tenderness

present. **Orange-juice** should be given to all infants coming under the physician's care after having been upon any of the proprietary foods, or condensed or sterilized milk, for any length of time. Such infants ought also to be placed upon an **uncooked milk mixture** at once. M. Ostheimer (N. Y. Med. Jour., June 25, 1910).

For children over a year, potato or other **fresh vegetables** may be given with advantage. For the later treatment of anemia and debility, **iron** and **codliver oil** may be employed.

Case of a boy of 6 who refused all food except boiled milk and rolls. After a year of this one-sided diet, he developed infantile scorbutus in a very severe form. Rapid recovery occurred on **raw milk** and **lemon-juice**. Glaser (Berl. klin. Woch., Feb. 3, 1913).

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INFILTRATION ANESTHESIA. See COCA AND COCAINE.

INFLUENZA, OR LA GRIPPE.
—DEFINITION.—An infectious,

contagious disease, characterized by acute inflammation of the upper respiratory tract and bronchi, a sharp constitutional reaction, marked prostration, and more or less frequent secondary involvement of the lungs, digestive tract, or central nervous system. It occurs either endemically or epidemically; some of the epidemics are of such magnitude and severity as to constitute a pandemic scourge.

SYMPTOMS.—The incubation period of influenza is at times very short—but a few hours, according to some,—while in other instances it appears to extend to four days, or more. Two days may probably be considered the average incubation period.

The onset is often conspicuously sudden, a person going to bed apparently

well and waking up with headache and malaise, or even experiencing sudden dizziness and weakness while at work. Chilliness and malaise are the commonest initial symptoms, though headache and unwonted body heat are sometimes those first noticed. More or less marked rigors may occur. According to Dubé, the best way to detect early an oncoming influenza during an epidemic is to take the temperature at regular intervals in the as yet apparently healthy subject.

Other typical early symptoms are pains in the back and limbs, ranging from mild to very severe; marked weakness; slight, dry cough, and frequently reddening of the fauces and obstruction to nasal breathing. Thirst is apt to be augmented and the appetite is reduced. By the second day the patient is, as a rule, distinctly worse. Congestion of mucous membranes, including the conjunctivæ and sometimes the gums and tongue, is more marked; photophobia may exist; the tongue may be coated; backache may be severe, and the bowels are usually constipated. Somnolence often exists, and prostration is marked. The expectoration is scanty and tenacious at first, later more copious, purulent, and often streaked with blood.

The temperature rises by the second day to 100° F. (37.8° C.) up to 104° F., (40° C.) according to the severity of the case. In the more marked cases it may have reached 103° F. (39.4° C.) on the first day. In many instances the condition is a "three-day fever," the temperature beginning to recede after the third day; in a considerable proportion, however, temperatures up to 104° F. (40° C.) or even slightly higher are reached for 4, 5, or 6 days, after which a descent to subnormal by

more or less rapid lysis is the rule. In general the curve is less regular than in typhoid fever, resembling the latter in that the evening temperature is the highest in the day. Some cases show 2 peaks in the temperature curve.

The pulse is sometimes relatively slow—76 to 110—in comparison with the temperature. Usually it is feeble, and it may be irregular or intermittent. Sweating is easily provoked, and various signs indicating a relaxed circulation exist. Not infrequently a dangerous extent of depression of the heart is produced. Dyspnea and cyanosis may occur in the absence of lung complications.

The nervous system appears to be very susceptible to the influenza toxin, and according to some, is the prime sufferer in this disease. The sudden and violent prostration may perhaps, be looked upon as an evidence of central nervous intoxication, as may also the severe, sometimes lancinating, pains in the limbs and back and the frontal and postorbital headache. In a minority of cases, pain may be experienced in the bones, chest, lumbar region, or testicle, or may simulate pleurisy, pericarditis, stone in the kidney or bladder, or hepatic or intestinal colic (Harris). Usually these pains are much improved after two or three days.

Delirium and sleeplessness, more or less pronounced, are not infrequent at the height of the disease. In some cases, however, especially among young children, persistent somnolence or a semi-comatose state is observed.

Not a few cases of influenza develop skin rashes. These may be diffuse or localized, and uniform or morbilliform. Their extent seems to bear no relation-

ship to the severity of the case, and as a rule they are readily distinguished from the eruptions of scarlet fever or measles by their situation and duration. Occasionally herpes about the lips is noticed.

The catarrhal symptoms vary considerably in different cases. In some patients there are repeated fits of sneezing, with pronounced coryza and lachrymation. The conjunctivæ are likely to be congested and painful; they may, however, be relatively dry and itchy (N. S. Davis). Certain cases are suggestive of hay fever or bronchial asthma. Precordial oppression may be such as to suggest angina pectoris. Initial or early epistaxis was a rather conspicuous feature in the 1918 pandemic. It is sometimes followed by acute catarrhal rhinitis with profuse muco-purulent discharge and orbital pain. The nasopharynx may undergo diffuse inflammation or there may be lacunar tonsillitis. The larynx may be the seat of acute catarrhal inflammation, with hoarseness and dysphagia. Cough is paroxysmal, distressing, and persistent (Thomson).

The usual absence of leucocytosis in influenza is of service in differentiation of the disease from many other acute infections, in which a definite leucocytosis occurs. The white cell count in uncomplicated influenza ranges between 5000 and 8000. Forbes and Snyder found it lowest on the second day of the disease and believe a relative lymphocytosis also characteristic of this affection. Synnott and Clark observed a case with only 1200 leucocytes. Erskine and Knight report a marked prolongation of the coagulation time of the blood in every case tested.

Convalescence from influenza is, as a rule, discouragingly slow, most patients

not being restored to approximately normal strength for several weeks after defervescence. Meanwhile, the patient lacks ambition and endurance, may appear neurasthenic, and in a few instances develops melancholia or hysterical phenomena. Occasionally, normal feelings and zest do not return for a number of months. During early convalescence rises of temperature readily occur upon slight exertion. A hacking cough and abnormal expectoration may persist for some time after recovery. Sequelæ in the form of lasting weakness of the circulation or disturbances of the respiratory tract not infrequently occur.

Clinical Types.—Marked variations in the symptoms of influenza render possible the recognition, not only of several different types or case groups showing certain combinations of symptoms, but also of certain forms seemingly unrelated to the disease. The following groups of uncomplicated influenza cases are recognized by W. L. Somerset: (1) Fever with accompanying chills, malaise, and headache, but no other symptoms; though usually mild and brief, these cases may continue febrile for 2 or 3 weeks. (2) Fever with pain in the limbs, back, and thorax. (3) Fever with physical and mental prostration. (4) Fever with catarrhal inflammation of eyes, nose, pharynx, tonsils, or larynx (usually the largest case group). (5) Fever with bronchitis, which may or may not be accompanied by the conditions in the preceding group.

More widely divergent groups of cases are as follows:

Gastrointestinal Type.—In this variety the catarrhal symptoms are centered in the digestive tract. There is early vomiting, which is likely to be

repeated. Often there are also abdominal pain and diarrhea. These symptoms show marked persistence, and resist treatment. The diarrhea may be serous, suggesting cholera, or bloody stools may be passed.

Nervous Type.—This may be said to exist where the nervous symptoms such as delirium or semicoma, are particularly striking. It is sometimes identified with the *typhoid type*, symptoms of the typhoid state being apparent. Neck rigidity, convulsive seizures, local paralyses, and hemiplegia, while nervous phenomena, are more properly considered under the head of Complications.

Cardiac Type.—This is characterized by symptoms of heart-failure, rapid, feeble, irregular pulse, dyspnea, cyanosis, and paroxysmal tachycardia.

Fulminating Type.—After a sudden onset associated with marked dyspnea, the patient becomes cyanosed, the pulse uncountable, and death occurs in from 24 to 48 hours.

Ambulatory cases of influenza occur, the chief danger of which is that they assist markedly in the propagation of the disease. Accurate differentiation of the mild cases of true influenza from ordinary acute catarrhal disorders is difficult, particularly in view of our present lack of definite knowledge of the cause of influenza.

Influenza in Infancy and Childhood.—The symptoms in these cases are much the same as in adults. In the usual, respiratory type the nasopharynx is prominently involved, and pulmonary complications sometimes follow. Peevishness and restlessness at night are noted, and cough may be present. In the gastric or gastroenteric form, when occurring in infants, the clinical picture resembles that of the

midsummer type of cholera infantum, anorexia, vomiting, and diarrhea suddenly making their appearance. Pronounced fever and flushing, and a high pulse and respiratory rate are noted, even in the absence of lung involvement. Apathy, meteorism, flatulence, a coated tongue, hyperemic fauces, and sometimes an odor of acetone are usual accompaniments. The acid, foul-smelling stools may cause inflammation about the arms and over the buttocks (Fischer). Müller has described an infantile septic form in which high fever alternates with subnormal temperature; in a few instances this condition proves rapidly fatal or recurs at more or less protracted intervals.

Influenza in Pregnancy.—When severe and associated with lung complications, influenza is an extremely serious affection and is associated with abortion or premature labor in a large percentage of cases, frequently followed by death of both mother and child (Bland).

COMPLICATIONS AND SEQUELAE.—**Respiratory Tract.**—*Pneumonia.*—Lung complications are chiefly responsible for the high mortality from influenza. The pulmonary involvement is oftener lobular than lobar. N. F. Friedman, in X-ray studies during the 1918 epidemic, observed, in early cases, marked peribronchial infiltration with a local or general mediastinitis. The condition then either became stationary, the patient showing clinical improvement, or the process rapidly extended into the lung structure with the development, as a rule, of a bronchopneumonia, usually bilateral, sometimes unilateral. In a few instances the pneumonia was lobar, being confined to one or more lobes; the right lower lobe was usually

that first involved. In these cases the movements of the diaphragm on one or both sides were impaired while in bronchopneumonia they were unaffected unless the infection was very extensive. Frequently the heart was distinctly bottled-shaped, owing to degeneration of the heart muscle with dilatation. A great similarity of the findings in the bronchopneumonias to those of acute pulmonary tuberculosis was noted.

Clinically, secondary pneumonia may be suspected where, in addition to fever, rapid pulse, and prostration, there is an increased respiratory rate, cough, and bloody sputum. Not infrequently no physical signs of pneumonia are elicited at the first examination. When apparent, they vary from impaired resonance, particularly over the lower lobes, with diminution of vesicular murmur and showers of crepitant or later subcrepitant rales, to more definite indications such as dullness, bronchial breathing and voice sounds, and increased fremitus and whisper. At first these signs may be confined to a small area, *e.g.*, in the upper portion of the right lower lobe or high up in either axilla. Physical signs of lobar pneumonia are sometimes elicited where the actual condition, as shown by the X-ray or autopsy, is a bronchopneumonia.

According to M. J. Synnott and Elbert Clark, disparity between the temperature and pulse rate, *e.g.*, a temperature between 104° F. (40° C.) and 106° F. (41.1° C.) coexisting with a pulse rate below 100 or even below 80, is a marked aid in the differentiation of influenzal pneumonias from those of purely pneumococcic origin. Stress is also to be laid on the early, marked, and progressive cyanosis, frequently

apparent before there are any demonstrable physical signs of pneumonia; the mental condition of either marked apathy or delirium; the marked prostration; the rapid progression of the pneumonia; the infrequency of herpes labialis; the variability in the characteristics of the sputum—mucoid, mucopurulent, blood-streaked, frothy, bloody, or thin “prune juice;”—the free, often painless, sometimes paroxysmal cough, and the tendency to relapse. Hector Mackenzie reports having seen several cases in which the physical signs of consolidation persisted for several months after influenzal pneumonia, then gradually disappeared.

Pulmonary Edema.—General edema of the lungs, associated with pericardial effusion, frequently supervenes in cases already complicated with severe pneumonia. It constitutes a relatively frequent terminal condition.

Empyema.—In occasional instances empyema follows the lung infection. Friedman, in his X-ray studies, noted empyema at times in the lobar type of secondary pneumonia, while in the lobular type multiple abscess formation took place. These relationships do not, however, always hold good, empyema sometimes following a bronchopneumonia.

Pulmonary Tuberculosis.—Acute lung involvement secondary to influenza sometimes passes, in turn, into active tuberculosis.

There is a large group of cases of influenza in which hemoptysis occurs, usually toward the end of the illness when there is slight cough, an increasing weight, and no tendency to wasting. The sputum is stained bright red. It contains pneumococci as the predominant organism, but no tubercle bacilli. In both suprascapular areas the breath sounds are

faint, and moist, granular adventitious sounds are abundant. The percussion note is somewhat impaired but there is no bronchial breathing. The temperature is irregular, but the pulse is not so rapid as it would be in a tuberculous toxemia. Subsidence of both temperature and physical signs occurs within a few weeks. Differentiation of such cases from those in which influenza insensibly runs into acute pulmonary tuberculosis can usually be made by careful chest examination, the sputum, and the progress of improvement. Horace Wilson (*Lancet*, Jan. 25, 1919).

Nervous System.—No acute disease has such varied nervous sequelæ as influenza. In the cerebrum the poison often causes a temporary intoxication unattended with permanent damage, but it may also cause intense and fatal congestion, with minute meningeal hemorrhages, meningitis, or finally acute hemorrhagic encephalitis. In some instances the complicating meningitis is of streptococcal or pneumococcal origin. Intense headache or neuralgias, restlessness or delirium, convulsions, paralyzes, stupor, and unconsciousness are the main clinical features in these cases.

Various types of neuralgia often complicate the disease, usually appearing as defervescence is taking place. Neuritis, more or less severe and extensive, is very common. As Harris states, "there is scarcely a nerve twig, or nerve trunk that has not been known to suffer from influenza, with resulting local tenderness and trophic symptoms of skin or muscle persisting for variable periods." These conditions, however, seldom terminate fatally. Neuritis of the various cranial nerves, brachial neuritis, sciatic neuritis, multiple neuritis, etc., have all been

met with. Paresthesias of all sorts have been reported as sequelæ.

Spinal affections which may complicate influenza comprise herpes zoster, acute anterior poliomyelitis, acute myelitis—usually cervical and accompanied by meningitis,—ascending myelitis, and Landry's paralysis. Progressive bulbar palsy and myasthenia gravis have also been recorded.

In the psychic sphere, the manifestations vary from those of delirium, melancholia, or delusions, to hysteroid convulsions, catalepsy, and trancelike states.

Certain visceral symptoms occurring early in the course of influenza may be attributed to disturbance of nerve-supply by the infection *e.g.*, the neurotic polyuria and watery diarrhea sometimes met with (Harris).

Circulatory System.—*Heart.*—The heart not infrequently becomes dilated as a result of influenzal intoxication. This is especially apt to occur in individuals past middle life, and in the obese and alcoholic (N. S. Davis). The condition often persists for weeks or months after the acute attack, the heart remaining irritable and its rate easily increased.

At the onset of influenza bradycardia and sudden syncopal attacks have been observed. Later, irregular rhythm and an extremely frequent beat (auricular fibrillation) are not infrequently met with. It is believed that myocarditis may be induced or accelerated by influenza. Eichhorst has reported a case in which intense tachycardia preceded other influenzal symptoms by one week.

Vessels.—Phlebitis, thrombosis, and embolism are occasional complications. Synnott and Clark observed gangrene of the foot from embolism in two cases. In the brain, thrombosis may

give rise to such manifestations as hemiplegia, motor aphasia, agraphia, and temporary blindness or hemianopsia. Sudden blindness has also resulted from embolism and thrombosis of the central artery of the retina.

Vascular relaxation due to the influenza toxin may be a favoring factor in the various forms of congestion and visceral hemorrhage observed by numerous authors.

Blood.—Synnott and Clark refer to several cases in which the infection produced a marked hemolytic effect, with rapidly progressive anemia. In one instance the red cells were reduced to 1,600,000 with 50 per cent. hemoglobin, by the fifth day of the disease.

Kidneys.—Acute nephritis secondary to influenza is relatively infrequent. Rather often, however, albumin and casts occur in the urine during the febrile period. Gotch and Whittingham, during the 1918 epidemic, even found albumin in 90 per cent. of all cases. Hyaline and granular casts were also found in 85 per cent. of cases of the five-day-fever type, and in 36 per cent. of cases of the three-day-fever type. The casts usually disappeared by the fifth or sixth day and the albumin by the eighth or ninth. Synnott and Clark observed retention of urine to be not uncommon. Influenza may also cause aggravation of a pre-existing renal disease, impaired renal function during protracted convalescence, or an actual postinfluenzal nephritis.

Special Sense Organs.—**Ears.**—Otitis is a common complication of influenza, and is characterized, on the whole, by rapid destruction of tissue, in spite of but slight suffering on the part of the patient, and by early mastoid involvement and extension to the meninges. Many cases of chronic otitis

media result (Davis). Thrombosis of the sigmoid sinus or of the jugular bulb have been met with. Ear complications were relatively infrequent in the 1918 epidemic.

Accessory Sinuses.—Aside from the more or less pronounced inflammation of the nasal passages, the accessory sinuses not infrequently become involved. Aching pains may result from a mere swelling of the lining of the frontal sinuses.

Eyes.—Eye complications are comparatively rare, but may be serious. They comprise conjunctivitis, inflammation of the lachrymal duct, herpes of the cornea or eyelids, iridochoroiditis, glaucoma, and nervous disorders of vision. Optic neuritis, with choked discs and retinitis, was not infrequent in the 1890 epidemic. Retrobulbar neuritis may seriously impair vision. Sudden blindness from embolism and thrombosis of the central artery of the retina has also been recorded. Various forms of ophthalmoplegia may be met with, *e.g.*, loss of accommodation or of the pupillary light reflex, ptosis, and paralysis of any of the extraocular muscles.

Olfactory Organs.—Permanent anosmia not infrequently results from influenzal involvement of these organs.

Hemorrhagic Complications.—Hemorrhage in influenza appears to be favored both by peripheral vascular relaxation and by reduced coagulability of the blood. In the 1918 epidemic epistaxis occurred very frequently, especially in children. Hemorrhage also took place into the bowel, stomach, bladder, skin (purpura and petechial hemorrhages), cerebrospinal fluid, and from the gums and ears. Erskine and Knight reported a case of sudden death during convalescence, apparently from

hemorrhage in the brain. Some pneumonia patients succumbed suddenly to asphyxiation due to active hemorrhage from the lungs.

Miscellaneous.—Jaundice, probably of infectious and not of obstructive origin—the stools not being acholic—was observed in many severe cases in the 1918 epidemic.

Subcutaneous emphysema in the neck, face, upper chest, and arm was observed by Synnott and Clark in 20 cases.

Among the rarer complications and sequelæ that have been reported are peritonitis, subphrenic abscess, rupture of the rectus muscles, pulmonary embolism following thrombophlebitis, thyroiditis, pneumothorax, gangrene or abscess of the lungs, serofibrinous pleurisy, suppurative pericarditis, anginal attacks, endocarditis, multiple arthritis, parotitis, persistent vertigo, and insomnia.

In some patients having the gastrointestinal form of influenza there finally occurs pain, tenderness, and rigidity localized in the right lower quadrant, marked enough in some cases to have led to the diagnosis of acute appendicitis. This involvement of the appendix is only a part of the enteritis of influenza. Recovery will take place unless secondary infection of the appendix occurs, as shown by the development of leucocytosis. Two patients developed leucocytosis, respectively, of 14,000 and 18,000. Appendectomy was done in each case under gas and oxygen anesthesia. C. J. Rowan (Trans. Western Surg. Assoc.; Med. Rec., Feb. 18, 1919).

DIAGNOSIS.—Recognition of influenza while an epidemic prevails is, as a rule, not difficult. In atypical, mild, sporadic cases, however, a correct diagnosis is often, in the present state of our knowledge, impracticable, since

the identity of the microorganismal cause of the disease is still in doubt and no certain bacteriologic means of diagnosis is available. That true influenza exists in a sporadic case, rather than a mere, ordinary "cold" is, perhaps, most satisfactorily indicated by such peculiarities as abrupt onset, unusual degree of prostration, relatively high fever, postocular pain, flushed face and eyes, backache, and marked pain in the extremities. Absence of a history of exposure to cold might serve as a distinguishing feature, influenza coming on more or less independently of such influences. From the present views as to influenza etiology, even the finding of the bacillus of Pfeiffer in pure culture in the discharges is not a definite proof of the existence of influenza. Jex-Blake warns against mistaking the onset of pulmonary tuberculosis for influenza. Such a mistake occurred in no less than 112 out of 416 unselected cases of tuberculosis. The leucocytic count is sometimes useful in the diagnosis of influenza.

Typhoid or paratyphoid fever may be suggested by the symptoms in the gastro-intestinal form of influenza. The distinguishing features of the latter in this connection are the sudden onset, the possible existence of an epidemic at the time, absence of rose spots, of splenic enlargement and of the typical temperature curve, and the negative results of the Widal or paratyphoid agglutination reaction and of blood cultures.

Cerebrospinal meningitis is sometimes closely simulated by influenza, which may cause painful retraction of the neck, vomiting, and other manifestations of a meningeal reaction—often passing off suddenly, however, after a few days. Lumbar puncture may con-

stitute the best, and almost the only, means of early differentiation in such cases.

Smallpox in its early stages is distinguished by an obstinate resistance to measures prescribed for symptomatic relief. Later, the rash settles any doubt.

Dengue is distinguished from influenza by the constant occurrence of a skin rash, the characteristic remission in the fever after the third day, and the more persistent pains in the joints and muscles, with a tendency to arthritis.

ETIOLOGY.—Although influenza occurs at all ages, young adults are the most frequently affected. Children below one year of age are relatively seldom attacked, while in middle and especially late adult age, an increasing resistance to infection is shown, possibly through an immunity established by an attack in a former epidemic.

Careful observation leaves no doubt but that a certain degree of immunity results from influenzal infection. Each pandemic appears so to immunize a considerable part of the population that another cannot occur until a new susceptible generation has grown up. Sahli deems it entirely possible that even those who escape influenza during a pandemic may imperceptibly acquire a partial immunity against the infection.

In spite of certain opinions to the contrary, the occurrence of influenza epidemics is seemingly not related to definite atmospheric or climatic states. In a given locality an epidemic generally reaches its height and shows marked decline within four to six weeks, though the remainder of the decline may subsequently occupy a prolonged period. Fresh outbreaks of

the disease, sometimes more severe than the initial one, may occur after an interval of apparent complete freedom from the disease.

The so-called "influenza bacillus" was described independently by Pfeiffer and Cannon in 1892, and is often termed the Pfeiffer bacillus. Its etiologic relationship to influenza, however is by no means established. Pfeiffer himself saw cases of "grippe" in which the germ was surely absent (Scheller). Not only have Pfeiffer bacilli been recovered from as high as 35 per cent. of sputums from normal individuals, but the germ has been found in a variety of diseases unassociated with influenza, *e.g.*, measles, diphtheria complicated by purulent bronchitis, whooping-cough, scarlet fever, tuberculosis, etc. When pathogenic, the Pfeiffer bacillus seems to be associated, most typically, with purulent inflammation of the bronchi and bronchioles (Kinsella).

Nevertheless, the Pfeiffer organism may occur in great numbers, and sometimes almost alone, in the mucopurulent flakes and clumps from the inflamed mucous membranes. The bacilli are very small rods, with rounded ends and staining most deeply at the ends. They grow best on agar which has been smeared with blood and form minute, gray, dewdrop-sized colonies. When they are grown with other microbes and especially with *staphylococcus pyogenes aureus* the colonies are larger and denser. The vitality of colonies on culture media is eighteen days. They are aerobic and grow only between 43° and 26° C. The bacilli stain slowly, and best with Loeffler's alkaline methylene blue. An exposure of from five to ten minutes to the stain is advisable (Davis).

Improved culture media for the influenza bacillus described. They include, blood boiled in agar, agar containing the clear colorless fluid resulting from boiling blood in water, and agar containing blood which has been broken down by the action of strong mineral acids. If a small quantity of brilliant green be added, the media become actively selective for the influenza bacillus by inhibiting the growth of pneumococci, streptococci, and staphylococci. Blood serum from influenza patients agglutinates the organism in dilutions of from 1 in 8 to 1 in 1000, while the serum from normal persons fails to agglutinate the organism even in a 1 to 4 dilution. Alexander Fleming (Lancet, Jan. 25, 1919).

According to some, influenza arises from the combined attacks of the Pfeiffer bacillus and other pathogenic germs—possibly with temporarily heightened virulence,—such as the pneumococcus, streptococcus, micrococcus catarrhalis, staphylococcus, etc. What is more certain is that, whatever be the true, primary virus of influenza, the complications of the disease, including especially pneumonia, are due to one or more of the organisms just mentioned, including, sometimes, the Pfeiffer bacillus itself.

The original researches of Nicolle and Lebailly, of Dujarric de la Rivière, and of Gibson, Bowman, and Connor, conducted in relation to the 1918 pandemic, resulted in at least a strong suspicion that the primary germ of influenza is a filtrable virus. Da Cunha, Magalhaes, and Fonseca, of Brazil, report the isolation of a filtrable diplococcus from the throat secretions and blood of influenza cases, while Bradford, Bashford, and Wilson describe minute, filtrable, coccus-like, anaerobic, gram-positive bodies, capable of producing severe and even fatal illness

when inoculated in monkeys or guinea-pigs.

Reference made to the investigations of Nicolle and Lebailly, which seemed to show that influenza is due to a filtrable virus, the disease having been transmitted to monkeys and to 2 men by the inoculation of the filtered bronchial secretions from acute cases. Foster's work shows the importance of a filtrable virus as the cause of common "colds." The authors succeeded in transmitting influenza to 2 monkeys by conjunctival and intranasal inoculation of bacteria-free filtrates from the sputum of acute cases. One monkey was made only mildly ill; the other was severely sick and was killed for examination on the third day of fever. The respiratory tract showed a hemorrhagic exudate, especially in the lower lobes of both lungs. The incubation periods were 6 and 7 days, which agreed with the observations on the 2 inoculated human beings. Gibson, Bowman, and Connor (Brit. Med. Jour., Dec. 14, 1918).

PATHOLOGY.—There is practically no distinctive pathology of uncomplicated influenza, the lesions present being merely those of acute inflammation of the mucous membranes of the nasal passages, pharynx, trachea, and bronchi. When, as is not infrequently the case, the accessory nasal sinuses are involved, the profuse mucopurulent discharge typically met with in sinus disease is witnessed. In the very rare cases of death from uncomplicated influenza, the inflamed condition of the mucous membranes has not been found perceptible post-mortem.

The chief pathological interest of influenza is that relating to its pneumonic complications. The primary virus is looked upon as so reducing the general powers of resistance to bacteria that organisms already present in the throat or introduced from the exterior readily

invade the deeper respiratory tract and cause pneumonia. Upon this secondary infection may be superimposed, immediately or after an interval, tertiary or quaternary infections with different organisms, which may or may not alter the lesions already produced.

MacCallum, in a study of pneumonia following influenza in army camps and at the Johns Hopkins Hospital, found it possible to differentiate pathologically between the secondary pneumonias due to the pneumococcus, the streptococcus, and the influenza bacillus. (1) In pneumococcal pneumonia, the lung on external inspection showed a lobular consolidation, usually affecting the posterior and lower part of each lobe. The cut surface showed a lobular consolidation corresponding in its details to the consolidation commonly described in the stage of engorgement in lobar pneumonia. Microscopically these areas showed marked dilatation of the ductuli alveolares, while the alveoli contained an exudate of fluid, fibrin, a few leucocytes and mononuclear cells, and often numerous red blood cells. At later periods, every transitional stage of pneumonia could be found, up to the most advanced lobar consolidation, with dense gray hepätization. (2) In streptococcal pneumonia, the interlobular septums were edematous, and the area of consolidation indefinitely outlined—in places red or almost black, due to laking of blood. The bronchi and alveoli were packed with leucocytes, blood, fibrin, and tangled masses of streptococci. The capillaries were often plugged with hyaline thrombi, and the bronchial walls infiltrated with leucocytes, the epithelium being lifted up or destroyed. Whole areas of lung, although retaining their form, were entirely necrotic, the alveoli being

packed with almost solid masses of streptococci, and the lymphatics likewise replete with them. (3) In Pfeiffer *Bacillus pneumoniae*, the bronchi exuded thick, yellow pus and the lung, though in large part air-containing, was studied throughout with shotlike nodules or somewhat larger, firm patches having a grayish yellow cut surface. The exudate in the bronchi contained leucocytes and numerous influenza bacilli, mostly intracellular. The bronchial walls were greatly thickened by infiltration with mononuclear cells, and the alveolar exudate, while usually rich in leucocytes, often consisted mainly of desquamated epithelium and dense fibrin, with extremely few influenza bacilli. Organization with fibrous tissue was advancing rapidly, the process being essentially an interstitial bronchopneumonia.

PROGNOSIS.—Death from uncomplicated influenza is rare, occurring in but a small fraction of one per cent. of the cases. Marked danger attends the disease, however, in certain epidemics from the liability to pneumonic or other complications. As many as one third of the cases may develop pneumonia, and of these, from 10 to 40 or 50 per cent. succumb. Greater likelihood of serious complications exists among those enfeebled by such chronic affections as tuberculosis, chronic bronchitis, myocarditis, nephritis, and emphysema, as well as among the very old or very young, than among other subjects. The liability to complications seems to vary markedly in different epidemics.

PROPHYLAXIS.—Immediate isolation of influenza cases is capable of limiting the spread of the disease, but must be carried out most strictly and persistently if it is to be effective. In

hospitals, convalescents should be separated from active cases, and especially, cases complicated with pneumonia should be kept separate, not only from uncomplicated cases, but from cases harboring different pneumonia-producing germs, as unfortunate results through cross-infection from one patient to another have been observed. Personal prophylaxis consists chiefly in avoiding street cars and all places where people congregate, in wearing a proper **gauze mask** (consisting of at least 5 layers of fine-meshed gauze, and with some provision for protection of the eyes), in **washing the hands after contact with possibly contaminated objects**, and in **keeping away from persons harboring the disease**. Nasal irrigations and gargling with **saline or antiseptic solutions** may be serviceable, but at least the first of these seems open to the objection that the infection may be spread over previously unattacked areas of mucous membrane. **Quinine** in small doses may possibly be of some prophylactic value. Marchant has suggested the liberal application to handkerchiefs of a fluid made by adding 120 drops of **oil of cinnamon** and 60 drops of formalin to 1 ounce (30 c.c.) of alcohol.

Mixed vaccines seem to have proven less effectual in protecting from the primary virus of influenza than from the secondary pneumonic infections. Since the latter, however, constitute the chief cause of mortality, vaccine prophylaxis in this direction, if feasible, is of considerable importance.

Examination of sputum and posterior nasal swabs in influenza showed a mixed and fairly constant flora. Such

organisms as streptococcus, pneumococcus, *M. catarrhalis* and *B. influenzae* were present in a high percentage of cases. The predominating organism being *M. catarrhalis* in 34 per cent., streptococcus in 30 per cent., pneumococcus in 26 per cent., *Staphylococcus aureus* in 8 per cent., and *B. influenzae* in 2 per cent. Prophylactic **vaccination** on 2 or 3 occasions with a weekly interval between each inoculation is without risk, increases the immunity of the individual, and prevents the onset of pulmonary complications. Cases with high pyrexia or toxic condition from the start should be treated with **polyvalent antistreptococcus serum**, 20 c.c. subcutaneously, as soon as possible, to be followed by daily injections of 10 c.c. for 3 or 4 days. **Calcium lactate**, 5 grains (0.3 Gm.) should be given daily for 7 to 10 days to ward off serum sickness. Vaccine treatment may be combined with this, if required. Whittingham and Sims (Lancet, Dec. 28, 1918).

At the State School, Wrentham, Mass., during the influenza epidemic 71 employees were vaccinated with influenza vaccine "B." Of these 5 later contracted influenza. Fifty-eight were not vaccinated; of these 38 contracted the disease. Thirty girls who constantly assisted in the care of the sick were vaccinated; of these 3 contracted influenza. In a building in which lived 156 inmates, 28 were vaccinated; of these only 1 contracted influenza. Of the 128 unvaccinated, all equally exposed with those vaccinated, 64 contracted the disease. G. L. Wallace (Boston Med. and Surg. Jour., Apr. 17, 1919).

During the influenza epidemic at Camp Sherman, Ohio, all members of the command were required to gargle twice daily with a 1: 10,000 **quinine gargle**. This was done because routine throat cultures early in the epidemic had shown the pneumococcus to be consistently present in large numbers in most of the throats examined. The pneumococcidal value of quinine in weak solution is thoroughly established. Friedlander, Mc-

Cord, Sladen, and Wheeler (Jour. Amer. Med. Assoc., Nov. 16, 1918).

Only 12 cases of influenza developed among 1500 malarial patients deeply under the influence of **quinine**, and in these the disease was exceptionally mild. This seems to show more or less of a protective action of quinine. After the disease is once under way, however, quinine does not seem to modify it. Roccavilla (Riforma Med., Feb. 1, 1919).

TREATMENT.—The influenza patient must be put promptly to bed and kept there well beyond the febrile period. Experience appears definitely to indicate that this measure not only reduces the severity of the disease and shortens the period of recovery, but tends to diminish the frequency of pulmonary and other complications. According to H. A. Christian, who calls attention to the frequency with which pneumonic changes in epidemic influenza exist unsuspected by the attending physician, the patient should remain abed for 1 week after defervescence in all cases in which the temperature at any time has risen above 101° F. (39.4° C.) for more than one observation during the 24 hours. Of 60 nurses and internes put to bed as soon as they became ill, none died, while all about them the wards were filled with dying patients, many of them neglected before admission and unable to have continuous rest in bed. During epidemics it is even advisable to have the apparently healthy take their temperature two or three times a day in order that fever, which may precede definite sensations of illness, can be immediately detected and the **rest treatment** begun as soon as possible (Dubé).

Plenty of **fresh air** should be admitted to the sick room, but it is of

great importance to *prevent chilling* of the influenza patient's body, as such chilling seems to interfere with the development of immunity and promote complications. The influenza patient often sweats, and the resulting wet garments predispose to chilling; frequent change of the body coverings may therefore be indicated. Upon their removal, the patient should be rubbed dry with a warm towel and warm, dry clothing donned without exposure from beneath the bed covers. Use of the urinal and bedpan should be ordered, to obviate the chilling which inevitably occurs when other procedures are followed.

Open air treatment of influenza recommended. The patients do not thrive as well in any ordinary hospital, no matter how well ventilated, as when they are put right out into the open, getting the direct sunlight all day long. Brooks (Amer. Jour. Public Health, Oct., 1918).

The **diet** in influenza should be simple, but the patient should, as a rule, be encouraged to take all the nourishment he can ingest without aversion, as the disease is *par excellence* one in which the resisting powers of the body must be conserved and everything possible done to facilitate the development of immunity. Milk, broths, gruels, and custards are suitable at first; later, one may gradually add or substitute soft foods such as eggs, milk toast, oysters, ice cream, cereals, etc., and finally return to an ordinary simple, solid diet. *Vomiting* may require abstention from food or limitation to a very light, liquid diet for a day or two. Horder, for vomiting, gives 1 minim (0.06 c.c.) of **tincture of iodine** in 1 dram (4 c.c.) of water every hour for 6 doses.

Fever in the influenza patient does not, as a rule, require any direct treatment, but **cool sponging** is sometimes indicated for continuously high fever.

The *headache, backache, and pains in the extremities* are appropriately treated with such drugs as **acetylsalicylic acid, sodium or other salicylate, acetphenetidin, antipyrine, pyramidon, or acetanilide**. A disadvantage of these agents is that they may induce an uncomfortable and even dangerous—owing to the possibility of chilling—degree of sweating, which the influenza patient very easily develops. As little as $2\frac{1}{2}$ grains (0.15 Gm.) of acetylsalicylic acid will sometimes cause a marked sweat. The very smallest dose sufficient for pain relief should therefore be used. Two grains (0.12 Gm.) of **acetphenetidin** or **pyramidon**, given every hour, may give complete relief within a few hours; where pain is severe, **codeine phosphate**, $\frac{1}{2}$ grain (0.03 Gm.) may be added to the antipyretic drug, providing its antitussive action does not contraindicate it (Fantus). N. S. Davis deems **salophen** a particularly good analgesic, which is not apt to disturb the stomach; he gives it in doses of 5 grains (0.3 Gm.) doses every 2 to 4 hours.

As little as 0.12 Gm. (2 grains) of **acetphenetidin** may yield relief from pain when given hourly for a few doses. For severe pain codeine may be given in doses of 0.03 Gm. ($\frac{1}{2}$ grain) when its depressant effect on cough does not contraindicate. Where cough is associated with retention of secretion, expulsion of the latter should be promoted by means of large quantities of liquids, the **iodides**, and 0.3-Gm. doses of **ammonium chloride**. Sleep must be secured, and may necessitate small

doses of **codeine** if repeated use of the **bromides, barbital, or hydrated chloral** have not been sufficient. In cases with obstinate vomiting it may be necessary to interdict all food and fluid by mouth for 24 hours, and to prevent dehydration and acidosis, **rectal saline injections** containing 2 teaspoonfuls of sodium bicarbonate to the quart should be given. Bernard Fantus (Jour. A. M. A., Nov. 23, 1918).

Following capsules used with excellent results: **Quinine salicylate**, 0.20 Gm. (3 grains); **acetphenetidin**, 0.15 Gm. ($2\frac{1}{2}$ grains); **camphor**, 0.02 Gm. ($\frac{3}{8}$ grain); given *t. i. d.* While the remedy lowers the temperature somewhat without causing perspiration, it acts primarily upon the neuralgic pains. H. Lychou (Svenska Lakare. Forh., Nov. 30, 1918).

Cough, when painful or disturbing, can be controlled with small doses of **codeine phosphate** or of **diacetylmorphine hydrochloride** to favor expectoration, Fantus, in mild cases, uses **ammonium chloride** in 5 grain (0.3 Gm.) doses, with a flavoring syrup vehicle, taken every 2 hours in $\frac{1}{2}$ tumblerful of water. In more severe cases, 2 grains (0.12 Gm.) of **sodium iodide** may with advantage be combined with each dose of the **ammonium salt**. To support the resulting secretory effect, fluids, such as milk, lemonade, or dilute grape juice, should be given. Fantus advises against codeine or opiates except in the event of a useless, non-productive cough in a patient whose chest is free of physical findings.

Where **coryza** is particularly marked, small amounts of **quinine sulphate, powdered camphor, and extract of belladonna leaves** may be given in combination with whatever analgesic drug is being used.

For influenzal sinusitis the writer prescribes **menthol**, $\frac{1}{2}$ dram (2 Gm.);

tincture of **eucalyptus**, 3 ounces (90 Gm.). A teaspoonful of this is put in a pint ($\frac{1}{2}$ liter) jug of steaming water, and the vapor inhaled up and down the nose every 2 or 3 hours. It generally relieves pain, frequently stimulates a free discharge, and patients are satisfied that it "clears the head." Relief to the frontal and sphenoidal sinuses may be secured by packing the neighborhood of the middle meatus, for a few minutes every day, with a pledget of cotton soaked in **cocaine** (5 per cent.) and **adrenin**. When the acute stage is past, a simple **alkaline nose lotion** may be employed. Inflammatory troubles of the pharynx and larynx are treated on ordinary principles. St. Clair Thomson (Pract., Jan., 1919).

Sleeplessness in influenza is often due to cough, and will then pass off when the latter is relieved. Frequently, however, a remedy which will simultaneously exert a mild hypnotic effect is desirable. Such remedies are **barbital** and **chloral hydrate**, in 5 grain (0.3 Gm.) doses. **Sulphonethylmethane** (trional), **bromides**, and **scopolamine hydrobromide** in small doses might also be used. Relief is very necessary, since sleeplessness weakens resistance and favors prostration. As a rule, remedial measures are required for only a few nights, although in some instances insomnia proves troublesome even after subsidence of the acute symptoms.

Initial purgation with **magnesium citrate** solution or a similar agent is often recommended, but a number of observers deem it useless. At all events, the bowels should be kept open during the course of the disease, if necessary by means of **enemas**, **suppositories**, or mild **laxatives**.

Warning against the abuse of purges at the start of influenza. In

grave forms with very low blood-pressure, **adrenin** may be useful. The writer gives 10 to 15 drops by the mouth 2 or 3 times. Given subcutaneously, it is apt to cause severe disturbance in these cases. The heart may have to be re-enforced with **camphorated oil** or **strychnine** or both. **Caffeine** is apt to bring on delirium. **Wet packs** about the chest, at 25° C. (77° F.), changed 3 or 4 times a day, render good service. With a tendency to pulmonary edema, **venesection** must be abundant and repeated; otherwise, wet cupping may suffice. The writer advocates moderate doses of **quinine** for its tonic action, *e.g.*, 4 grains (0.25 Gm.), morning and evening. Lereboullet (Paris méd., Nov. 16, 1918).

Prostration in influenza is treated, in the first place, by **rest**, **fresh air**, and a sufficient **diet**. Administration of stimulant drugs may be availed of in addition. **Caffeine**, **strychnine**, and **quinine** are available for this purpose, but care should be taken not to induce sleeplessness. Where a tendency to a circulatory impairment is observed, these agents may again prove useful, but injections of **camphor** in oil in amounts of 1 to 2 fluidrams (4 to 8 c.c.) a day, and the use of **digitalis**, **strophanthus**, or **adrenin**, are also available. In cases with pallor, thready pulse, syncopal tendency, and the "white line" phenomenon, Lyon recommends **adrenin** in doses of 5 drops of the 1:1000 solution by mouth every hour, up to 30 or 40 drops a day. Lereboullet sometimes substitutes injections of whole **adrenal extract** from ampoules, each corresponding to $1\frac{1}{2}$ grains (0.1 Gm.) of the extract.

While there is no specific drug or treatment for influenza, many practitioners have felt convinced that **quinine** is of distinct value. Pos-

sibly, benefit may be obtained through the stimulating action of this alkaloid, in proper dosage, upon phagocytosis,—an action repeatedly observed experimentally. According to H. Lyon Smith the best dosage for this purpose, to be administered during the initial stages, is 1 grain (0.06 Gm.) for every stone (14 pounds) of the patient's weight.

Calomel in so-called tonic doses, $\frac{1}{2}$ grain (0.005 Gm.) every two hours until 1 grain (0.065 Gm.) has been taken, to enhance the antitoxic activity of the liver, followed, if there is no cough, by **sodium benzoate**, 10 grains (0.65 Gm.) every three hours, or, if there is a cough, by **creosote carbonate** (which, though an oil, is preferably given in capsules), 5 grains (0.3 Gm.) every three hours, taken in the midst of a meal when possible to prevent gastric disturbances, has served us faithfully even though pulmonary phenomena had already begun. Editorial (N. Y. Med. Jour., Dec. 21, 1912).

Alkali treatment advised in epidemic influenza. The measures used are as follows: Immediate elimination through profuse sweating induced by large bowls of **hot boneset tea**, and divided doses of **calomel**, $\frac{1}{10}$ grain (0.006 Gm.) every half hour until a grain or more has been given. **Water** given exclusively for the first 24 or 48 hours, and freely throughout the attack. **Hot mustard foot baths** are used, the patient being kept in bed covered with blankets and surrounded with hot water bottles. A teaspoonful of **sodium bicarbonate** to a pint of lukewarm water is given every 4 hours by **enema**. Also **sodium bicarbonate** $\frac{1}{2}$ ounce (15 Gm.), **peppermint water** 4 ounces (120 c.c.), one teaspoonful every 2 hours, alternating with the same dose of **potassium citrate** $\frac{1}{2}$ ounce (15 c.c.), **peppermint water**, 4 ounces (120 c.c.). Calcium salts are given in the form of **lime water**, $\frac{1}{3}$; milk, $\frac{2}{3}$. Some patients with fulminant attacks of vom-

iting and terrific headaches could not tolerate the **potassium salts**; to such were given only the **sodium bicarbonate** mixture every hour, and the **soda enemas**. Even in severe cases the soda relieves the early pains in 24 to 48 hours. T. C. Ely (N. Y. Med. Jour., Apr. 5, 1919).

Colloid metals were used in the 1918 epidemic with asserted benefit. P. Richard injected **colloid gold** in the form of gold collobiase intramuscularly in 30 minim (2 c. c.) doses on 2 to 4 successive days in incipient influenza and obtained uniformly a prompt recovery. Capitan used **colloid arsenic** and **colloid silver** in combination in both mild and severe cases, and asserts that this treatment lowered the mortality in cases complicated with pneumonia. Simonin explains the favorable effect of the colloids as being due to stimulation of leucocytic activity. Wanner, to assist nature's defence, counsels an early injection of **electrargol** and the institution of a **fixative abscess** with turpentine.

Other remedies recommended include **alkalies**, freely administered, **calomel** in small doses for several days, **mercuric chloride** intravenously, **tincture of iodine** internally, **methylen blue** in doses of 3 grains (0.2 Gm.) 4 or 5 times a day, **hexamethylenamine** intravenously to the amount of 30 to 45 grains (2 to 3 Gm.) a day, **venesection** for cases with dyspnea and cyanosis in the absence of pneumonia, and **salicin**, 20 grains every hour for three or four hours.

Hot packs around the chest and **fixation abscesses** aid in subacute cases still capable of reacting. **Venesection** should be tried in cases with cyanosis and pulmonary edema, but it is not so useful for toxic processes as

for vasomotor disturbance. Merklen (Bull. de la Soc. Méd. des Hôp., Oct. 11, 1918).

To reduce the tendency to hemorrhage, early use of large doses of **calcium lactate** apparently gave good results. There also seemed to be less bleeding in the pneumonia patients who took **calcium iodide** for their cough. Erskine and Knight (Jour. Amer. Med. Assoc., Nov. 30, 1918).

Arsphenamine given by the mouth and by the veins in 38 cases of the gravest forms of influenza at the height of the epidemic. The death rate was reduced to 21 per cent. Bruhl and Franck (Bull. de la Soc. Méd. des Hôp., Dec. 20, 1918).

The writer treated 225 cases of influenza and pneumonia in the 1918 epidemic without losing a patient. At the first visit he gave a mixture of **tincture of aconite** and **tincture of veratrum viride**, to be continued every half-hour until 6 to 10 doses had been given. At the same time he gives 2 or 2½ grains (0.12 or 0.15 Gm.) of **calomel** in ¼-grain (0.016 Gm.) doses, crushing the tablets and mixing with a little water. Six or 8 hours after the last tablet, 1 or 2 heaping tablespoonfuls of **magnesium sulphate** are taken. This treatment will abort pneumonia in many instances. On the first indication of a failing pulse or the slightest trace of cyanosis, the best **brandy** or **whiskey** obtainable was given in teaspoonful doses every 3 hours, increased if necessary to a tablespoonful every hour. B. S. Maloy (Trans. Amer. Public Health Assoc.; Med. Rec., Jan. 11, 1919).

Influenza patients treated with **gelsemium** showed improvement greatly exceeding that after any other treatment. Following mixture used:—

R *Tr. gelsemii*, ... ℥xij (0.73 Gm.).
Tr. belladonnae, . . . ℥v (0.33 Gm.).
Potassii citratis, gr. x (0.66 Gm.).
Syr. aurantii . . . 3j (4 Gm.).
Aq. chloroformi
 ad ʒj (30 Gm.).

Sig.: One ounce (30 c.c.) 4 hourly for the first 24 hours; thereafter ½

ounce (15 c.c.) every 4 hours until temperature is normal.

When the temperature reaches the normal the remedy should be stopped. In severe toxic cases with marked pulmonary symptoms, where tremor is marked, the pulse unstable, and the patient collapsed, alcohol in the form of **brandy**, **whiskey**, or **champagne** acts best. **Inhalations** of **menthol** and **benzoin** greatly relieve tightness in the chest. Small and Blanchard (Brit. Med. Jour., Mar. 1, 1919).

Encouraging results seem to have been obtained by the use of **vaccines** for the prevention of complicating pneumonia. At Camp Upton, subcutaneous injection of a lipovaccine containing 10,000 million each of Types I, II, and III of the pneumococcus appeared not only to immunize against these organisms but also to result in a very low incidence of streptococcal pneumonia cases.

A curative vaccine containing 5 millions each of the streptococcus, pneumococcus, and *M. catarrhalis*, and 2 millions each of the meningococcus and *B. influenzae* was used in early cases by Whittingham and Sims with asserted good effect; it was given daily until defervescence occurred. In cases showing high pyrexia or a toxic condition from the start, 20 c.c. of polyvalent **antistreptococcic serum** was also given, followed by daily injections of 10 c.c. for three or four days.

Prompt treatment with **vaccines** (pneumococci, streptococci, and influenza bacilli), within a few hours of the onset will definitely abort an attack of influenza. Where bronchopneumonia is present from the first, vaccine seems often to have the same good effect, when injected early.

The fall of temperature is associated with improvement in the patient's aspect and in the pulse and respiration rate, thus indicating that

it is due to a definite immunizing influence. Inadequate dosage is to be avoided. Wynn (Pract., Feb., 1919).

Bacterial protein injections employed in influenzal pneumonia. In spite of massive consolidation, good results were obtained when there was a definite reaction following the injection, and the authors therefore came to believe that the results were dependent upon a "non-specific protein" reaction. A vaccine made from the prevalent organisms, however, was used. A saline suspension of heat killed organisms was made, so that each cubic centimeter contained 100 million influenza bacilli, 100 million pneumococci, types I, II, and III; 100 million streptococci, and 100 million staphylococci. The initial dose was 5 c.c. and this was doubled daily until four doses had been given. Later they used 1 c.c. as the initial dose and regulated the succeeding doses by the amount of reaction. Reaction occurred as a rule about $\frac{1}{2}$ hour after the injection. Out of 86 cases treated expectantly there were 27 deaths, a mortality of 31.2 per cent. Of 200 cases treated with protein injections, there were 19 deaths, a mortality of 9.5 per cent. Roberts and Cary (Jour. Amer. Med. Assoc., Mar. 29, 1919).

Pooled serum from **convalescent** influenzal bronchopneumonia patients at the U. S. Naval Hospital, Chelsea, Mass., was used by McGuire and Redden in 151 pneumonia cases. The mortality was greatly lowered and the disease shortened. The maximal amount of serum administered (intravenously) at a dose was 250 c.c.; the usual amount, 75 to 125 c.c. Most patients received a total of about 300 c.c.

Injecting various sera, such as normal human serum, serum obtained from convalescents, normal horse serum, antidiphtheritic serum, etc., in influenza patients, the writer generally noted a marked improvement

at the end of 36 hours. E. Reiss (Deut. med. Woch., Nov. 28, 1918).

The writer employed intravenous injections of from 75 to 100 c.c. of **citrated convalescent blood** in the treatment of 54 of the severest cases of pneumonia following influenza, and reduced the mortality to 27 per cent. The reaction produced was about like that seen after the use of antipneumococcic serum in lobar pneumonia. The temperature often fell by crisis, sometimes after a single injection, at others after 2 or 3 injections in 36 hours. More commonly, however, the fall was by rapid lysis. MacLachlan and Fetter (Jour. Amer. Med. Assoc., Dec. 21, 1918).

Thirty cases of so-called influenza pneumonia treated by the use of **human serum** from convalescing patients with a loss of only 2 cases. There was rapid and complete subsidence of symptoms. Such serum undoubtedly contains valuable antibodies, and its use in cases infected with homologous strains will give satisfactory results. With the present limited ability to isolate the infecting organisms of the donor and the recipient, however, the method cannot yet be placed on a practical basis where definite results can reasonably be expected. Gould (N. Y. Med. Jour., Apr. 19, 1919).

Special stress has been laid upon the use of **antipneumococcic serum, Type I**, in cases in which this type of pneumococcus is found. It seems preferable, however, to use the serum at once without waiting for the results of laboratory examination, to avoid the loss of valuable time. Spooner, Sellards, and Wyman have emphasized the advisability of using high titer serum rather than large quantities of lowgrade serum.

The other therapeutic measures indicated in influenzal pneumonia are those employed in pneumonias unrelated to influenza. Coryza, bron-

chitis, sinusitis, gastritis, and other complications are likewise treated as under other conditions.

In over 6000 cases treated at Camp Dix, distressing cough was relieved by **codeine** or **heroin**. **Medicated steam inhalations** were helpful for laryngeal irritation. **Digitalis** was started early in the pneumonia cases, given in full doses for 48 hours, and then discontinued or reduced in dose when the heart was well digitalized. If abdominal distention developed, it was relieved by **enemas** or **pituitary solution** administered by the hypodermic route.

Water was given by rectum, subcutaneously or intravenously if the patient was toxic or unable to take fluid freely by mouth. The **Trendelenburg position** proved helpful in a few cases with pulmonary edema. The **diet** should provide over 3000 calories daily, and be made up of gruels, broths, purées, eggs, and milk fortified with cream and lactose. **Serum** was given in cases of pneumonia due to Type I pneumococcus, preliminary desensitization being practised in every case. It was given intravenously in doses of 60 to 100 c.c. every 12 hours until the temperature remained below 101° F. 38.3° C. **Spinal puncture** was made in all cases showing symptoms of meningeal irritation, the precipitin test for pneumococcus type made on the fluid, and **serum** in a 20 c.c. dose given intraspinally at once if Type I proved present. At the same time a desensitizing dose of serum was given and 5 hours later a dose administered intravenously. Synnott and Clark (Jour. Amer. Med. Assoc., Nov. 30, 1918).

In intensely toxic cases with a tendency to paralysis of the vasomotor centers, the writer found the effectual treatment is **adrenin**. Subcutaneous or intravenous injections of 0.001 Gm. ($\frac{1}{64}$ grain) several times a day keep the pulse going well but do not modify conditions in the lungs. A **fixation abscess** seemed to do good service in some cases. F. Wan-

ner (Corresp.-Blatt. f. schweizer Aerzte, Dec. 28, 1918).

In the cases with complications in lungs and bronchi which do not clear up rapidly, injections of 2 c.c. ($\frac{1}{2}$ dram) of 10 per cent. **camphorated oil** with the addition of 0.10 Gm. ($\frac{1}{2}$ grains) **guaiaicol**, twice daily, are very useful. The fever drops and all the symptoms abate. **Counterirritation to the chest**, **proctoclysis**, and **digitalis**, were also used as indicated. Bassoni (Policlinico, Feb. 9, 1919).

Lung puncture employed in influenza pneumonia in a series of 41 patients, many very seriously ill, with favorable results. It is conducted under strict asepsis, and consists merely in puncturing the consolidated area with a large size needle or trocar which is allowed to remain in the lung for 30 seconds. The seat of election for the puncture is either the axillary or the scapular line. M. Benaroya (Lancet, May 3, 1919).

For the persistent **neuralgia** and **neuritis** following influenza the customary analgesic drugs may be used, along with general roborant treatment. Blum, of Strasbourg, found **methylene blue**, 3 grains (0.2 Gm.) 4 or 5 times a day, of distinct value in obstinate neuritis. **Fresh air**, **sunshine**, **change of climate**, a generous diet, **iron**, and **strychnine** are also helpful or even essential. Where muscular weakness and atrophy result, **electricity**, **hydrotherapy**, and **massage** are indicated.

Capillary hemorrhages in influenza indicate, according to Lesné, a vasodilating action by the disease toxins, and justify the use of **adrenin** in large doses.

Where cough and expectoration persist for several weeks and arouse fear of developing tuberculosis, Nammack has found a combination of **terpine hydrate**, **creosote**, and **strychnine** useful.

Post-influenzal empyema indicates pleurotomy, whether the causal organism is the pneumococcus, streptococcus, or other germ. The incision should be made, as usual, in the eighth or ninth interspace, in front of the posterior axillary line, but is to serve only for the evacuation of the pus and the admission of a finger to determine the lowest point of the corresponding pleura. Here drainage should be instituted, either through a second incision 6 to 8 centimeters long, or by prolongation of the first incision to the eighth or ninth rib, which should thereupon be resected in the anterior axillary line. Incision of the pleura should next be effected under control of the intrapleural finger. The evacuation of membrane should always be completed with a wad of cotton mounted on long forceps. One or 2 large drains are placed in the anterior incision.

The post-operative treatment consists in intermittent irrigation through 1 to 3 Carrel tubes introduced in the first incision. The irrigation is begun 24 hours after the operation and practised every 3 hours with some antiseptic fluid, such as **Dakin's solution**; **saline solution** and **ether**, **phenol**, or **borax**; **starch iodide**, etc., injected without much pressure and in small amount. As a result the temperature descends within 24 to 48 hours, unless severe lung involvement co-exists. The irrigation is stopped after 8 or 10 days, or may be continued on the following days as a simple pleural lavage with the syringe. The patient is gotten out of bed as soon as the temperature has approached normal, and is requested to walk regularly in his room. Of 20 cases thus treated, the authors lost only 2, through concomitant lung involvement. The remaining patients recovered within 15 to 30 days, without emaciation or chest deformity. Berard and Dunet (Bull. de l'Acad. de méd., Dec. 17, 1918).

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Philadelphia.

INFUSIONS, SALINE.

INTRAVENOUS INFUSION.—By this method saline solution, plain or medicated, is introduced directly into a vein as distinguished from intra-arterial infusion and hypodermoclysis.

Solutions.—The solution used is usually normal physiological salt solution that is isotonic with the blood—9 parts of sodium chloride to 1000 parts of sterile water. The proportions, however, may vary between 0.6 and 0.9 per cent. In practice it is about 0.7 per cent., being made by dissolving 1 dram of chemically pure sodium chloride in 1 pint of water. This solution is sterilized by heat and filtered into flasks sterilized by washing with bichloride solution and rinsing afterward with sterile water, the mouth of the flask being tightly stopped with sterilized non-absorbent cotton.

The flasks and contents after being thus prepared are sterilized for one hour on three successive days at a temperature of 220° F. After the last sterilization the cotton stoppers and mouth of the flasks are covered with a small square of thin rubber tissue held in place by a rubber band. When needed for use the flask is placed in a deep vessel filled with hot water, and left there until the contents are raised to the proper temperature.

Another method is to heat one of the flasks until the contained solution boils. A portion of the cold solution is poured into the reservoir first, and its temperature is raised by adding sufficient of the boiling solution.

Solutions other than plain saline have been suggested for use with the idea of approaching as nearly as possible the identity of the blood-serum. The following (called artificial sera) are most in favor:—

Hare's formula:—

Calcium chloride gr. iv (0.25 Gm.).
Potassium chloride .. gr. iss (0.1 Gm.).
Sodium chloride 3ii¼ (9 Gm.).
Distilled water Oij (1000 c.c.).

Hayem's formula:—

Sodium chloride 3i¼ (5 Gm.).
Sodium sulphate gr. xv (1 Gm.).
Distilled water Oij (1000 c.c.).

Locke's formula:—

Calcium chloride gr. iij (0.2 Gm.).
 Potassium chloride gr. iss (0.1 Gm.).
 Sodium bicarbonate ... gr. iss (0.1 Gm.).
 Glucose gr. xv (1 Gm.).
 Sodium chloride $\text{℥}\text{ii}\frac{1}{4}$ (9 Gm.).
 Distilled water Oij (1000 c.c.).

Ringer's formula:—

Potassium chloride gr. iij (0.2 Gm.).
 Sodium bicarbonate gr. iij (0.2 Gm.).
 Sodium chloride $\text{℥}\text{ii}\frac{1}{4}$ (9 Gm.).
 Distilled water Oij (1000 c.c.).

Szumann's formula:—

Sodium chloride $\text{℥}\text{iss}$ (6 Gm.).
 Sodium carbonate gr. xv (1 Gm.).
 Distilled water Oij (1000 c.c.).

Apparatus.—This comprises a graduated glass irrigating jar with a capacity of 1500 c.c., provided with a thermometer and about 6 feet of $\frac{1}{4}$ -inch rubber tubing, terminating in a blunt-pointed metal infusion cannula; a piece of bandage to constrict the area above the seat of operation, and a gauze compress and bandage for postoperative dressing of the parts.

Instruments.—A scalpel, blunt-pointed scissors, thumb-forceps (mouse-toothed), aneurism needle, needle holder, two curved needles with cutting edge, and No. 2 plain catgut for ligatures.

Asepsis.—The principles of asepsis observed in major operations should be carried out. The instruments and apparatus should be boiled, the thermometer should be placed in a 1:500 solution of bichloride for ten minutes, and then rinsed in sterile water. The operator's hands and the patient's skin should be sterilized by the usual preoperative toilet.

Details of the Solution.—The temperature of the solution should be at least 105° F., and, should the added stimulating effect of heat be desired, it may be 115° F., or even 118° F. This seemingly high temperature of the solution will be lowered 2° or 3° in flowing from the reservoir to the site of operation. In any case the solution should be introduced at a uniform temperature throughout the operation, and the thermometer within the reservoir will indicate the necessity of adding hot solution occasionally to maintain this equable temperature.

The rapidity of the flow may be regulated in two ways: By raising or lowering the reservoir, or by compression on the rubber tube by fingers or clamp. The usual rate of delivery is from five to ten minutes for each pint of solution. If the heart is weak more time must be consumed or acute dilatation of the heart may be produced. If the delivery is too rapid it may happen that the fluid passing from the heart to the lungs may be nearly pure salt solution. Very soon difficult respira-

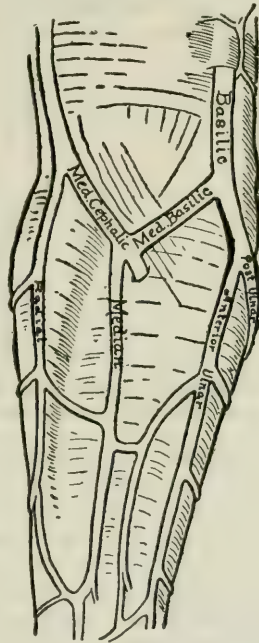


Fig. 1.—The superficial veins of the forearm.
 (Ashton.)

tion and restlessness will ensue as a result of imperfect oxygenation of the blood; in this case the infusion must be interrupted until these untoward symptoms disappear.

The amount of solution infused usually varies from 1 to 3 pints, being governed by the return of the pulse, the increase in its volume, and by the improvement in the color of the patient's skin. It will be readily appreciated that the capacity of the circulatory apparatus is limited, and that if this limit is exceeded the solution will escape into the tissues and produce edema. Larger quantities of solution may be needed, however, after venesection or severe hemorrhage. As a rule, it is wiser

to repeat the infusion two or three times during the twenty-four hours than to infuse too much at one time.

Operative Site.—The median basilic vein, which runs across the bend of the elbow from without inward, is the favor-

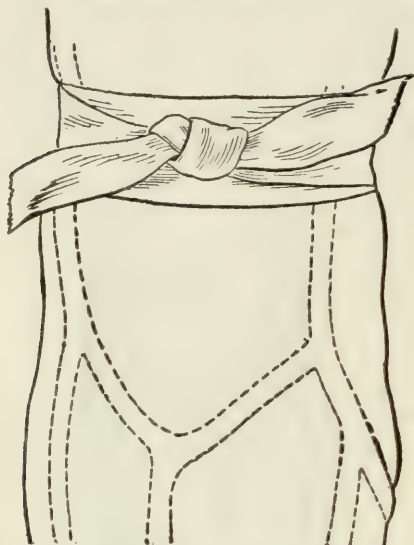


Fig. 2.—Showing the application of the bandage to the arm to constrict the veins. (Ashton.)

ite site. Dawbarn recommends the use of the internal saphenous vein anywhere above the ankle for the reasons that it is as large or larger, that there are no important structures nearby, that the scar left is unobjectionable as to location, and that the assistants will interfere less with the operating surgeon than if the arm is used.

Preparation of the Patient.—The area around the site selected for the infusion should be bared of clothing, and the garments about the axilla, if the arm is selected, should be loosened. The bend of the elbow should be shaved, scrubbed with warm water and soap, washed with bichloride solution (1:2000), and rinsed with sterile water. To compress the veins and make those below more prominent a piece of sterile bandage is tightly tied above the elbow (Fig. 2).

The site of entrance is anesthetized by infiltration with a freshly prepared 0.2 per cent. cocaine solution, or by freezing with ethyl chloride spray or a small lump of ice dipped in salt.

Operative Technique.—The forearm being supinated, a transverse incision is made over the median basilic vein (Fig. 3), which is loosened from the adjacent structures for a distance of from 1 to 1½ inches, then brought out of the wound. Two catgut ligatures are passed beneath it by means of an aneurism needle, or by a pair of thumb forceps (Fig. 4). One ligature is placed as low down on the distal portion of the vein as possible and tied. The second ligature is placed as high up as possible on the proximal portion of the vein, ready to be tied. A short distance from the distal ligature the exposed vein is grasped in the mouse-toothed forceps, and, while the vein is on the stretch, an oblique cut is made with the scissors through half the vein, exposing its interior (Fig. 5). Allowing the solution to flow through the cannula to expel any air or cooled fluid, the cannula with the solution still flowing through it is inserted well up into the proximal portion of the cut vein (Fig. 6) and is re-

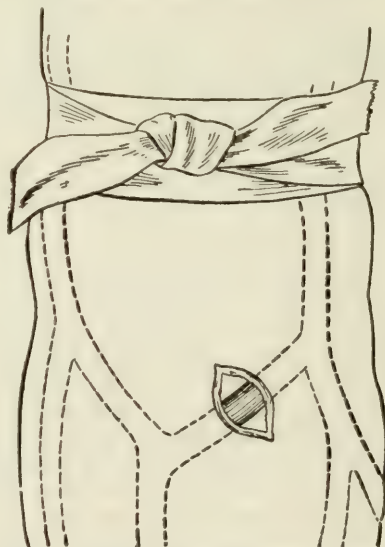


Fig. 3.—Intravenous saline infusion. (Ashton.) First step, showing the vein exposed by a small incision.

tained in place by tying the second ligature (Fig. 7), preferably in a bow-knot, that it may be easily loosened when the cannula is withdrawn. The bandage, previously tied above the elbow, is removed and the solution allowed to enter the cir-

culution, the reservoir being raised from 2 to 6 feet above the patient to produce the necessary pressure. The thermometer in the reservoir must be constantly watched that the temperature of the solution be kept uniform. The fluid in the reservoir must be replenished before it has entirely escaped, else air will enter the vein when a fresh supply is added.

When the desired amount of solution has been infused, the ligature around the cannula is loosened, and the cannula is removed. The ligature in place is now used to tie off the proximal end of the vein (Fig. 8). The wound is closed

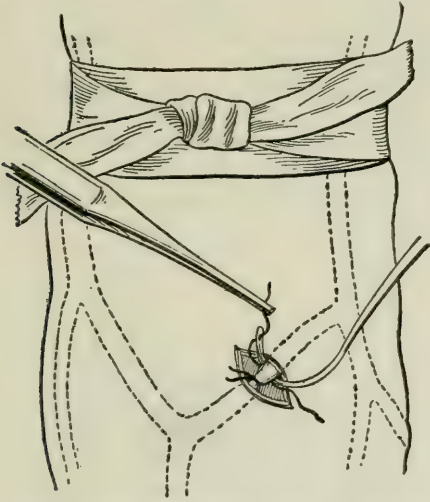


Fig. 4.—Intravenous saline infusion. (Morrow.) Second step, showing the distal end of the vein tied and a second ligature being passed under the proximal end of the vein.

with catgut sutures; a sterile gauze compress is applied and retained by a gauze bandage.

Intravenous infusion may be performed without incising the skin. The only change in apparatus is the substitution of a hypodermic or a small aspirating needle for the blunt cannula. The needle with the solution flowing through it is inserted through the skin directly within the vein.

INTRA-ARTERIAL INFUSION.—By this method saline solution, plain or medicated, is introduced into the artery instead of a vein. It may be injected into the distal end of the vessel, or into the proximal end against the blood-current. It has been claimed for this method that, being first

forced through the capillaries, the solution is received by the heart more gradually and more evenly mixed with the circulating blood. A stimulating effect upon the heart is claimed for the infusion against the blood-current. These advantages are more imaginary than real; in-

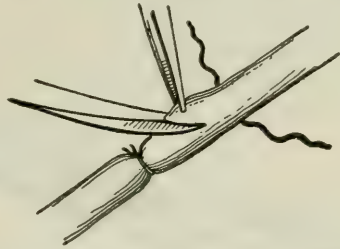


Fig. 5.—Intravenous saline infusion. (Morrow.) Third step, showing the method of incising the vein.

travenous infusion should be the method of choice. In suspended animation during anesthesia or from other causes Crile and Dolley have shown that the infusion of normal salt solution and adrenalin into an artery against the blood-current is the most efficient method of raising the blood-pressure and stimulating the heart, as the blood and solution are driven back to the heart, directly affecting the coronary arteries, thus raising the blood-pressure,

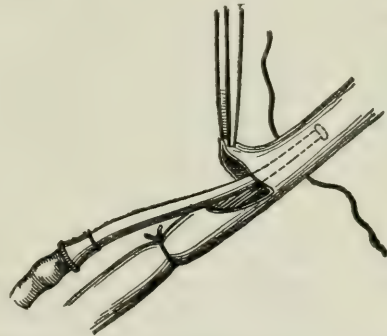


Fig. 6.—Intravenous saline infusion. (Ashton.) Fourth step, showing the cannula being inserted into the vein.

and inciting the heart to renewed action. By this method they have resuscitated apparently dead animals.

Apparatus.—The same apparatus as employed for intravenous infusion, or a large glass funnel attached by a length of $\frac{3}{4}$ -inch rubber tubing to an infusion cannula,

may be used, or even a hypodermic syringe.

Operative Site.—The carotid artery or one of its larger branches is the site of choice, as the coronary arteries are most directly reached through these vessels.

Technique.—The following technique of arterial infusion for the purposes of resuscitation is that of Crile (Amer. Jour. of the Med. Sci., April, 1909): "The patient, in the prone position, is subjected

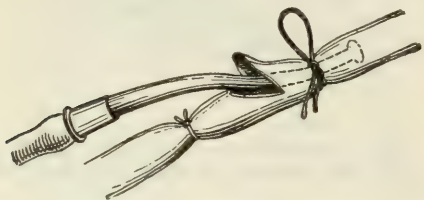


Fig. 7.—Intravenous saline infusion. (Morrow.) Fifth step, showing the cannula tied in place.

at once to rapid rhythmic pressure upon the chest, with one hand on each side of the sternum. This pressure produces artificial respiration and a moderate artificial circulation. A cannula is inserted toward the heart in an artery. Normal saline, Ringer's, or Locke's solution, or, in their absence, sterile water, or, in extremity, even tap water is infused by means of a funnel and rubber tubing armed with a cannula. As soon as the flow has begun the rubber tubing near the cannula is pierced by a hypodermic syringe loaded with 1:1000 adrenalin chloride, and from 15 to 30 minims (1 to 2 c.c.) are at once injected. Repeat the injection in a minute, if needed; synchronously with the injection of the adrenalin, the rhythmic pressure on the thorax is brought to a maximum. The resulting artificial circulation distributes the adrenalin that spreads its stimulating contact with the arteries, bringing a wave of powerful contraction and producing a rising arterial, hence coronary, pressure. When the coronary pressure rises to, say, 40 mm. or more, the heart is liable to spring into action, the first result of which is to spread still further the blood-pressure-raising adrenalin, causing a further and vigorous rise in blood-pressure, possibly even doubling the normal . . . Just as soon as the heart-beat is es-

tablished, the cannula should be withdrawn, first, because it is no longer needed, and, second, the rising blood-pressure will drive a current of blood into the tube and funnel."

DAWBARN'S METHOD OF INTRA-ARTERIAL INFUSION.—This is an emergency method of injecting saline solution into the blood-stream of the common femoral artery, the necessary apparatus being an ordinary Davidson or a fountain syringe armed with a hypodermic or a long, fine aspirating needle. Dawbarn especially recommends its use in the absence of a cannula and the usual apparatus for the intravenous method, and where the superficial veins are small and difficult of location.

Technique.—After locating the femoral artery just below Poupart's ligament, it is pierced at right angles by the aspirating needle, by a slow rotary movement. When the needle enters the lumen of the artery

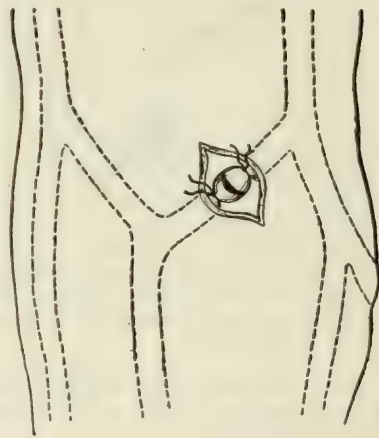


Fig. 8.—Intravenous saline infusion. (Ashton.) Sixth step, showing the infusion cannula removed and the proximal end of the vein ligated.

bright-red blood will fill the needle. The rubber tubing of the syringe filled with saline solution is slipped over the base of the needle and tied securely. The fluid may then be slowly and steadily pumped from a basin or other container into the arterial circulation, a half-hour being used to inject one pint of solution. In using a fountain syringe the latter should be raised at least 6 feet above the patient, not only to provide the necessary pressure,

but also to prevent the blood from backing up in the tube.

HYPODERMOCLYSIS.—This method of subcutaneous infusion is often used as a supplement to intravenous infusion. It is also used for the same purposes as intravenous infusion when time is not important. Like the latter, it is 'contraindicated in cases of advanced dropsy, pulmonary edema, and of marked cardiac insufficiency, in which latter condition the circulation is so feeble that the solution is very slowly absorbed or not at all.

Apparatus.—This is the same as that used for intravenous infusion, with the exception that the cannula is replaced by an aspirating needle of medium size. When the fluid is to be introduced under both breasts simultaneously, a Y-shaped glass connection is used at the distal end of the tubing, allowing the use of two aspirating needles, which are joined to the legs of the Y by shorter lengths of rubber tubing. For emergency purposes an apparatus may be improvised with a glass funnel, rubber tubing, and a hypodermic needle.

Asepsis.—The same measures should be taken toward this end that are described under intravenous infusion.

Details of the Solution.—As in intravenous infusion, the solution should enter the body at a temperature of 110° F. In using an aspirating needle the temperature of the fluid should be 3° higher, and when a hypodermic needle is used it should be 5° warmer. The solution is not absorbed so rapidly by this method; and with a medium-sized needle and the reservoir elevated about 3 or 4 feet, 1 pint of solution may be injected during about twenty or thirty minutes. When a hypodermic needle is used the reservoir must be elevated 5 or 6 feet to obtain an equal force.

Small injections (from 8 to 16 ounces) repeated in a few hours are better than larger injections given at one time. Hildebrand fixes the limit of quantity to be injected during fifteen minutes at 1 dram to each pound of body weight. If this limit is exceeded the tissues become waterlogged and absorption ceases, the kidneys being unable to excrete the water with sufficient rapidity. Very large injections

should not be made into a single area, as they may cause undue distention and sloughs.

Injection Sites.—Those locations are chosen which are rich in loose connective tissue and reasonably free from large blood-vessels and nerves; for example, under the mammary glands, between the iliac crest and the last rib, in the axillæ, and on the inner surface of the thighs. The point of puncture may be anesthetized by the use of cocaine, ethyl chloride, or ice and salt.

Technique.—The reservoir, containing the warmed saline solution, and connected up with the tubing and aspirating needle, is first raised 3 or 4 feet and the cold liquid and air are allowed to escape. With the solution still flowing the needle is inserted obliquely into the subcutaneous tissues of the selected site, using steady pressure. As the fluid enters the tissues they become distended, but this distention slowly subsides as the fluid becomes absorbed (massage will hasten the absorption).

It is well to enter the needle well into the tissues at first and when one area becomes distended the needle may be withdrawn a little and the direction slightly changed. By repeating this maneuver the fluid in considerable amount may be spread over a wide area without overdistingending any one portion of the injected tissues. As in intravenous infusion, the temperature of the solution in the reservoir must be maintained at the same point, and the solution must be present in amount sufficient to exclude all chances of air entering the delivery tube.

When the desired quantity of the solution has been injected, the needle is withdrawn, and the finger-tip placed over the entrance to prevent the escape of fluid; later the puncture is sealed with a pledget of sterile cotton dipped in collodion.

PAINLESS HYPODERMOCLYSIS.—Willard Bartlett (Annals of Surgery, Feb., 1921) advocates local anesthesia from the beginning to the end of the procedure by introducing very dilute novocaine instead of straight salt solution or distilled water. Gradually increasing amounts of fluids are used, in which the percentage of novocaine is cut down first from $\frac{1}{2}$

to $\frac{1}{4}$, then to $\frac{1}{8}$, and finally to $\frac{1}{16}$ of 1 per cent., without the anesthetic value of the drug being appreciably diminished. The $\frac{1}{16}$ per cent. novocaine solution suffices for the introduction of fluid under the skin. **Adrenalin** is added where hypodermoclysis is used in shock and hemorrhage. The apparatus is the ordinary 700 c.c. glass drip bottle, a rubber tube 1 yard in length, controlled by a screw clamp, and a slender, long needle. The best site is the flank midway between the lower ribs and the prominent upper curve of the ilium. Less subsequent damage has occurred there than elsewhere, and less pain than under the breast.

W.

INTERNAL EAR, DISORDERS OF.—The percipient apparatus of the ear is relatively rarely affected and furnishes but 2 to 10 per cent. of the cases in the statistical tables,—the larger figure embracing apparently every case which gives evidence of nerve involvement, however secondary in fact and importance to tympanic trouble. It comprises the congenital defects as well as the central lesions, such as nerve atrophy in tabes, word-deafness from cortical lesion, and many other rare cerebral affections; but the group which most concerns us in this practical review is made up largely of lesions of the labyrinth due to the specific affections, including syphilis.

TUNING-FORK TESTS.—The diagnosis of these affections is largely from negative evidence, much of it furnished by the tuning-fork tests of the function, and these had better be here considered.

Tuning-forks can be conveniently used giving tones due to vibrations of from 50 to 2000 per second, and much can be learned by use of $A = 213$ d. v. s. or $C = 520$ d. v. s. alone; but it is not best to trust to any one tone. The lower forks must usually

have clamps to dampen the overtones (such can be improvised by slipping bits of rubber-tubing over the ends), and in the absence of such will often give the notes one or two octaves higher coincidentally with their fundamental. For this reason and for its convenient duration of vibration I prefer the $A = 213$ d. v. s., of medium size, more often found in the shops, or one flattened to the even 200. Such a fork, struck upon some rather soft surface by falling its own length, should generally be heard some ninety seconds through the air when held before the ear; while with its handle resting upon the mastoid or other portion of the skull or face, it should be audible slightly less than half as long. It should be heard equally in each ear from points in the middle line of the head; and the sound-waves should escape from each canal, as can be heard through the auscultation-tube. Stopping the canal with the finger should increase the sound in the closed ear to a degree that extinguishes its perception in the other and makes the sound again audible by bone-conduction after it has been normally lost. Low tones are heard relatively better by bone; high tones, by air: so high-pitched forks should have long handles if their use on the mastoid is to be free from probable fallacy. Low-toned forks should be lightly struck to test bone-conduction, lest their vibration on the head should be oppressively loud.

If we place the vibrating A-fork on one mastoid it should be heard for some forty seconds, as stated, and for some fifty more when transferred to the front of the canal; and each other fork has its fairly definite proportion for a normal ear, equal on

the two sides. But in deaf ears the finding will be different and discrepant perhaps on the two sides. Lesion of the conducting-apparatus will impede alike the entrance of sound-waves by air and their escape from the tympanum when awakened there through bone-conduction. Hearing by air-conduction will be subnormal, by bone-conduction it will be exaggerated; the proportion changing from 90:40 to perhaps 30:50, bone-conduction preponderating. This is Rinné's or Schwabach's test,—modified by Roosa very practically by merely noting whether it is "louder front or back," as almost any patient can rightly decide.

If the deafness be due to the perceptive apparatus, the normal preponderance of air-conduction will continue, bone-conduction being relatively worse, or, perhaps, totally lost. The proportion may now be A. C. 40: B. C. 10. So, too, from the middle line of the head the hearing will be worse in the worse internal ear, whereas if the trouble be in the conducting-apparatus the more obstructed ear will be the one hearing louder by bone-conduction. This is Weber's test.

Gardiner Brown modified Weber's test by resting the tuning-fork on the bridge of the nose and having the patient raise his finger just when he ceased to hear its vibration. As this should be exactly when the vibrations ceased to be felt by the fingers of the examiner, a rough, but practical, measure is gained (for each ear if unequal) of the increase or decrease of the bone-conduction, and the result is conveniently stated as + 3", — 4", etc.

Cases will frequently be met where

these tests give uncertain or contradictory results. Patients will give their preconceptions instead of observing the actual perceptions, unwilling to say that they hear by bone louder in the ear which they know to be worse, or confusing palpable vibrations with their weakened auditory perceptions. A deaf-mute will often claim to hear the fork as well resting on the patella as when on the mastoid. Yet a little patience and variation of the tests will generally clear up contradictions. The high tones are later and in less degree lost in tympanic affections, unless thickening of the drumhead shut out some such sound as the impure tone of the watch-tick.

In the diagnosis of lesions of the static labyrinth—*i.e.*, of the semicircular canals and vestibule—we are indebted especially to Bárány for a series of valuable tests, involving generally the production of nystagmus. This rhythmic motion of the eyes is seen often as the mere oscillation of eyes with imperfect fixation or in the strained eyes of miners, but is then made up of to-and-fro excursions of equal rapidity, little influenced by the direction of the gaze. In the nystagmus here considered there is a slow movement of the eyes to one side, due to stimulus from the opposite labyrinth or cerebellum, followed by a quick (cerebral) movement of readjustment. As this is often not exactly in the horizontal plane, it is called a "rhythmic rotary nystagmus." Although the significant phase is really the slow movement, which in some cases especially of cerebellar disease is a fixed conjugate deviation, the quick component has attracted more notice and the

nystagmus has been named "to the left" if the quick motion is to that direction. Normal eyes will often show it slightly if turned to the extreme position of lateral rotation: it is merely the wavering of the overtaxed abduction. Such motion is slight and equal on the two sides. In labyrinthine cases it is unequal: rotation of the eyes to the affected side usually exaggerates the quick motion; the nystagmus lessens or may wholly cease on looking to the opposite side. Such conjugate deviations of the eyes were ascribed by Högye to preponderant stimulation of the cerebellar-vestibular center of the side opposite and may be due to hyperactivity of this center or reduction of function of that on the other side. Ewald showed that endolymph flow toward the ampullar end is stimulant in the horizontal external canal, depressant or inhibitory in the superior vertical canal. It may be easiest to remember that "stimulant flow is *up* in the *upper* canal."

It is requisite, then, to have some means that can stimulate one labyrinth at a time, in order to test the functional competency of each. The most natural stimulant of this sort is rotation, to which the nystagmic movement of the eyes is a physiological reaction. If the patient be seated in a revolving-chair and turned steadily to the right ten times, for instance, there is created a current in his right horizontal canal toward the vestibule and away from it in the left. Such a flow is stimulant on the right, sedative on the left; the eyes tend to move slowly to the left with quick, nystagmic jerking toward the right. But this is hard to observe in the revolving patient. Stop the rotation

of the chair and the patient and study his eyes; we can now note the nystagmus ascribable to the continued movement of the endolymph in his ampullæ. Just as a matchstick floating on the water in a tumbler is unmoved by quick rotations of the vessel to and fro, because inertia holds the supporting fluid unmoved; but is carried round by steadier rotation when friction on the sides has imparted rotation to the water, and continues to revolve after the glass has ceased to move; so this **after-turning nystagmus** supplants the other and persists for some thirty seconds equally on the two sides if there is no difference in the excitability of the two labyrinths. The actual flow of the viscid endolymph in the capillary semicircular canal must be small, but this persistence is evidence for its reality; and the suggestion has been made that there are more hair-cells on one aspect of the crista ampullaris, on the proximal side in the superior, on the distal side in the horizontal canal, to account for the unequal stimulation caused by the direction of the flow. If we time, best by using a stop-watch and with the eyes cut off from fixation by opaque glasses, the duration of the nystagmus first to the one side and then to the other, we have a fairly practical measure of the relative excitability of the two labyrinths. By bending the head forward or back so as to bring the superior canals into the horizontal plane of rotation, we can submit them to a like testing: yet full differentiation is difficult, and not only is vertical nystagmus probably always a compound movement in the component direction caused by both superior and posterior canals, but

even the rotary element of the horizontal nystagmus shows that the rotation is not precisely in the plane of the approximately horizontal semi-circular canals.

A similar measure for testing one labyrinth at a time is furnished by the "caloric test" of syringing one ear with water colder or warmer than the body temperature. This depends upon the law of convection of heat by fluids, in that injection of hot water causes a flow upward in that canal which the pose of the head brings into the vertical plane; cold water causes the reverse effect. The pressure of the fluid, which can cause vertigo and nystagmus, is to be avoided by steady gentleness. Cold water, *i.e.*, of about 70° F., is more commonly used, as it causes more prompt but fleeting reaction; if the head be erect it should give flow down toward the ampulla in the superior canal. This is the direction of inhibition for this canal, giving preponderance to the opposite labyrinth and a slow movement of the eyes toward the syringed side with quick movement to the opposite—"nystagmus away from the syringed ear." With the head thrown back the same effect should be produced; if bowed forward, the reverse. Vertigo is apt to follow too prolonged a test. No nystagmus will result if the cold fails to reach the labyrinth because of pathological obstruction, or finds it unresponsive through destroyed function: the test can be made in a doubtful case after the tympanum has been eviscerated, with the patient still under ether.

Galvanism is likewise able to stimulate the labyrinth upon which the cathode is acting, so the inefficiency

or overaction of 4 to 5 milliampères can furnish information as to its function, although some slight effect may be ascribable to the vestibular nerve-trunk, even after the labyrinth has been destroyed.

A fourth test is known as the "fistula test," since it is apt to evoke nystagmus in response to pneumatic pressure or suction exerted upon a labyrinth abnormally open toward the external canal, as by a fistula in its wall. Suction should cause a slow movement of conjugate deviation toward the open horizontal canal; pressure, a deviation away from it. The reverse effect is to be expected if the action is on a fistula in the superior canal; less definite results if the opening be about the oval window: nystagmic response would at least indicate a functioning labyrinth on that side. Mere vertigo is sometimes extreme in cases with lax annular ligament or other undue mobility of the fenestra, even though the ear has never suffered a suppurative lesion—pressure and suction seeming to have the same effect.

In any of these tests the nystagmus, when marked, may be easily recognized, even under the closed lids, and its duration timed by the watch. Slight oscillation may require that the patient's eyes be excluded from fixation by opaque spectacles, be turned to the side of the rapid component, and light reflected upon the globe under the uplifted lid. When no spontaneous nystagmus exists, we time its duration from its inception to its disappearance; when it pre-exists, we try to measure the duration of the exaggeration.

The catarrhally deaf usually hear relatively or even actually better in

a noise,—“paracusis Willisii”; whereas those with nerve-deafness are made worse by it. Very high tones, such as given by the Koenig rods or the Galton whistle, may be inaudible to a diseased labyrinth or portions of the gamut may be lost, while all voice-tones, as well as much deeper notes, are normally heard. Yet in these cases, while all the vowel-sounds may be heard, however pitched, there is a loss of consonants, whose subtle variations and slight energy make weak impression on the impaired percipient mechanism: “the sound but not the sense” will be gained. Add the confusion of coincidental noises, as in general conversation, and those so affected may be wholly disabled; and the uncomprehended jargon of voices becomes almost maddening. These limitations must be learned and borne in mind; then the tuning-fork tests will generally be found to lead to correct diagnosis; and the many instances of mixed affection will be noted, as well as those which are totally differentiated.

Diagnosed in the manner outlined above there will be a small, but important, group in which there has been a small-cell infiltration of the labyrinth as the result of syphilis, acquired or inherited or of cerebro-spinal meningitis, or typhoid, or other fevers. The onset of the deafness may be sudden, usually without vertigo, or it may be stealthy and gradual. Acoustic hyperesthesia may precede it, and the condition may be very unequal on the two sides. In children, who are its more frequent victims, it is generally only noted that they do not hear or that they are not talking as they should. Convul-

sions without defined or protracted illness may be reported as the starting-point, or trauma with loss of consciousness. The deafness following mumps may belong in this category, but generally seems rather a toxic acoustic paralysis.

SYPHILIS.

The stigmata of inherited syphilis are to be sought in the typical facies, with its exaggerated nasolabial lines; the high-vaulted palate; wide-spaced and pegged incisor teeth, only sometimes notched; the clouded corneæ, or nodes upon the shin or other bones. The family history, with miscarriages and early deaths or typical lesions in other members, may be our only evidence.

TREATMENT.—Whether syphilitic or not, the same treatment is indicated. Absorption of the infiltration by **mercurials** and **iodides** constitutes our main resort. In recent specific cases Politzer’s vigorous use of **pilocarpine** has given excellent results in some cases; but the treatment cannot always be borne, is inconvenient with its sweatings, and can hardly equal for the ear or for the general condition the usual anti-syphilitic medication. Long-standing cases offer little prospect of benefit, but they have been known to gain beyond all expectation, and the underlying disease may in itself demand this treatment. Salvarsan has been charged with precipitating if not causing injury to the acoustic nerve.

LABYRINTHINE EFFUSION (MENIERE’S DISEASE).

Another notable group includes the cases of labyrinthine effusion causing vertigo and deafness, generally associated with Ménière’s name.

"The Ménière complex of symptoms" is now generally spoken of, and some writers have not only differentiated tympanic vertigoes, but have inclined to deny the reality of "Ménière's disease." Yet, clear-cut cases of this affection do undoubtedly occur, and the influenza epidemics caused not a few of them. The seizure is usually apoplectiform, with intense vertigo, not infrequently with severe nausea and marked tinnitus and deafness. Some cases note the dizziness only on rising, but others are almost as distressed by it while at absolute rest in bed. Whether the acoustic or the co-ordination areas of the labyrinth are the seat of the lesion, both functions are at first profoundly affected; but the mere serous effusions can probably be absorbed completely, leaving no loss of hearing. As the labyrinthine vertigo is usually an *irritative* lesion, disappearing equally whether resolution or destruction be the result, it is possible that all of the profound affections are exudative or hemorrhagic. Some cases of typical labyrinthine apoplexy recover almost completely, but with a permanent gap at some part of the auditory scale.

In the vasomotor type of aural vertigo, where the fleeting character of the symptoms forbids any assumption of extravasation or sometimes even of serous effusion, great benefit is frequently gained from **adrenal therapy**. The desiccated gland in 2- or 3-grain (0.13 to 0.2 Gm.) dose several times a day can greatly steady the circulation, as can **strychnine** and other **tonics**. As an emergency dose **adrenalin chloride**, $\frac{1}{100}$ grain (0.00065 Gm.), can be carried in the pocket and kept at the bedside, for it is often

on attempting to rise in the morning that the patient suffers the vertiginous crisis.

Suppuration and necrosis of the labyrinth have been increasingly recognized by the symptoms in the last decade, but especially have been found unheralded after radical opening of the diseased middle ear. Necrotic areas or fistulous openings of its outer wall, most often on the convexity of the external or horizontal semicircular canal where its protrusion narrows the junction of attic and antrum, have been recognized and surgically dealt with. Removal of the dead bone opens the canal and for a while disablingly drains off the perilymph; yet healing can take place with preservation of function if the lesion be circumscribed. In the more extensive lesions there is generally loss of hearing as well as of equilibrium. Spontaneous nystagmus, vertigo, and impaired muscle-sense may wholly disable the sufferer; but often the process is more insidious. Tests of the static labyrinth may at first show undue and perverted irritability; later there will be no reaction on the affected side. The patient has to learn anew to balance himself, making fullest use of sight and muscle-sense in the effort, unstable as a three-legged stool that is poised on two legs. Darkness or closed eyes, even a sudden upward glance, may deprive him of visual compensation,—an unexpected slope of his standing ground may disconcert it,—while a dive into water may so rob him of the help of gravitation as to make him quite unable to come again to the surface. The dangers in his avocation may call for intervention to remove limited lesions or fully

destroy the diseased labyrinth, aside from the prognostic indication that many of the cerebellar abscesses and meningitis attacks are due to labyrinthine suppuration. The tympanum must first be eviscerated to give access; then we can open the ampullæ above the facial canal, the posterior canal behind it, or the region of the oval window below it—by any of these routes entering and curetting the vestibule. It has been found not generally needful to destroy each ampulla—this quickly follows destruction of the vestibule; but all carious bone should be removed. Tinnitus, vertigo, and other symptoms have often been most successfully relieved as a prompt result, and in skilled hands the mortality, although notable, has not been high.

TREATMENT.—Total **rest** in bed, **derivatives**, and perhaps **bloodletting** should be first tried, followed by **absorbent alteratives**. Charcot's use of **heroic doses of quinine** should be a last resort, as a means to complete the destruction of tissues incapable of resolution.

The effect of quinine, salicylic acid, and other drugs upon the labyrinth is often misunderstood. They certainly cause hyperemia in physiological dose; but probably here, as elsewhere, in toxic doses produce profound ischemia, such as is seen in the eye in quinine-blindness. Diseased ears are apt to be especially susceptible to the tinnitus and other discomforts of these drugs; but it is an open question whether they are more prone to be injured by them than normal. Malarial affections may leave marked or total deafness when no quinine has been given; and many a case has unjustly drawn

blame upon the physician because he has given quinine when his only error, if any, has been in giving too little. Just as in the tympanic inflammations, stasis must be overcome at times; and quinine is often our best, if not the most comfortable, means to this end. As the prejudice against it is widespread, however, great caution must be employed in its use; even those with anemic tinnitus, who find prompt relief from its exhibition, showing sometimes the greatest reluctance to taking it.

Akin, perhaps, to these cases are the losses of hearing following mumps, diphtheria, and other acute affections. They can, perhaps, be best compared to the blindness following ptomaine poisoning from sausage and such foods. There is certainly microbic invasion of the labyrinth in some of the diphtheritic cases; but these are apt to show the more usual septic inflammatory reactions. Acoustic atrophy, like that of the optic nerve, generally calls for an **alternative course** to limit and repair, if possible, the ulterior lesion, **followed by vigorous strychnine stimulation**.

OCCUPATION-DEAFNESS.

Finally, the matter of "occupation-deafness" demands our consideration, since it offers a valuable field for prophylaxis. "Boilermakers' deafness" is met among workmen in many trades where noise is great and continuous; but the riveter inside a boiler is naturally the most prone to suffer with the effects of such concussion upon his acoustic apparatus. Tampons have been employed with slight palliative effect; but the sufferer had best change his work to a

safer one. Tympanic affection may be coincidently active and demand appropriate treatment, but should not blind us to the deeper condition. The rapid-fire automatic gun is likely to claim many victims in this way, just as the dentist's electric hammer paralyzed the nerve-supply of many teeth before its dangers were recognized. So, too, the various methods of persistent pneumatic or phonomassage have wrought much damage already and are likely to find countless victims yet, who are misled by a brief stimulation of the torpid nervous apparatus and press on with the measure until all acoustic reaction is exhausted.

TINNITUS.

Tinnitus is a symptom rather than an affection, as to which much remains to be learned. Where it is high pitched and of long standing little expectation of its disappearance should be raised; but it ought to be generally possible to reduce it to a mild annoyance. It is at times strictly cerebral; may be due to turbinal pressure in the nose; but is generally of tympanic origin and can be benefited by treatment of the coincidental deafness. Yet it may have no relation to any defect of hearing, occurring when it is unthreatened or persisting after it has been restored. General vascular conditions must be looked to in the blowing type of noises, and **dietetic** rather than medicinal measures resorted to. **Pneumatic massage**, most easily employed with the finger-tip, will often do much for its relief.

While anode closure is the more usually helpful, cathode opening may in certain cases prove more efficient

in reducing or silencing tinnitus. Most otologists have abandoned electricity as less valuable than their more usual methods and all too easily harmful.

B. ALEXANDER RANDALL,
Philadelphia.

INTERTRIGO, ERYTHEMA INTERTRIGO, OR CHAFING.—

DEFINITION.—An hyperemic affection of the skin characterized by an erythematous condition produced upon contiguous surfaces, accompanied with an exudation of sweat with maceration of the skin.

SYMPTOMS.—Intertrigo is produced through closeness of contact between two apposing surfaces. The juxtaposition may cause irritation whether assisted or not by friction. It is an affection of hot weather, but may also occur in the winter. Heat acting directly on the subject and thus indirectly upon contiguous areas assists in its production and extension. It occurs in regions such as the nates, groins, axillæ, the spaces between and beneath the breasts in the female or in corpulent males, as well as overlapping portions of the abdomen, the sulci of the fingers and toes, and, in fact, any redundant portion of skin.

At first there is only an erythematous blush, but this soon increases in degree and in extent. Prolonged contiguity may lead to a true traumatic erythema, which with the retained sweat causes maceration of the adjacent portions of skin. If allowed to continue, the maceration may extend and end in a true inflammatory process.

In infants intertrigo is apt to be an annoying affection, especially when it occurs through inattention to the parts after micturition and defecation. Eczema is likely to supervene if no attention be given. The rubbing is also encountered after horseback riding, rubbing of tight-fitting boots or clothes, etc.

In infants acute enterocolitis is frequently the cause of intertrigo through the irritating discharges. It should be overcome by **dieting**: stop milk; give rice, arrowroot, or albumin water, with plenty of pure water

to allay thirst. Internally, give **sodium phosphate**, 5 to 10 grains (0.3 to 0.6 Gm.) every morning for two or three days, usually followed by **castor oil**, 1 dram (4 c.c.). Locally, **soak the parts with oatmeal water**. Give an **oatmeal bath**, by soaking bag filled with oatmeal in tub filled with boiling water for one-half hour, then allowing to cool to 100° F. and giving child hip bath. Then use following salve: **Calamin** and **zinc oxide**, of each, 3 parts; **petrolatum**, 50 parts. Dust parts with cornstarch or wheat flour. Use salve three times daily, previously cleansing parts with olive oil, if necessary. Fischer (Medical Era, Oct., 1911).

The parts are hot and tender, if not actually painful, and movement causes a scraping sensation. In an unattended case bleeding may occur as a result of fissures and removal of the upper layers of the epidermis. The parts emit a disagreeable odor, and, according to Crocker, of London, stain—but do not stiffen—linen: a point which this author adduces as of diagnostic value between eczema and intertrigo.

DIAGNOSIS.—The diagnosis of this condition is not difficult. The fact that there are two apposing surfaces in which there is a retention of sweat, emitting a disagreeable odor, and causing maceration and fissuring of these surfaces, should be sufficient in most cases. Removal of the cause is generally followed by an early cessation of the symptoms. Eczema will persist for shorter or longer periods, according to the extent of surface involved, and not alone will remain in position, but will also increase, if not judiciously treated. In the latter affection there is some degree of infiltration and thickening, which does not occur in erythema intertrigo unless eczema complicates the process. Congenital syphilis may also be confounded with this affection, but the fact that syphilis extends far beyond the borders of the contiguous surfaces will generally suffice to prevent error. Syphilis also produces a darker discoloration. An "*erythème syphilitiforme*" is noted by A. Fournier, which begins as a papulovesicle and resembles the vaccine papule; but as

these lesions are to be found in repeated succession, error is hardly possible.

ETIOLOGY.—The causes of intertrigo are manifold. Warm weather or heat produced by artificial means during the winter season may act as an inducing factor. Exaggerated exercise, rowing, running, horseback riding, as well as sedentary habits as observed in clerks who sit for long periods who wear unsuitable undergarments, and sweating at contiguous points are known causes. Friction, with or without moisture, will induce it. Secretions—such as saliva (the cases, for instance, following repeated protrusion of the tongue and licking the parts), vaginal discharges, unremoved feces during the existence of a diarrhea, the dribbling of urine, and the complication of glycosuria—are as many etiological factors. Many other conditions contribute to assist in its production and extension, such as the milk upon garments of careless mothers, which, thus being allowed to dry, roughens and stiffens the dressings, so that rubbing is soon induced. In young infants improperly washed diapers are also causative media.

TREATMENT.—As a rule, little or no treatment is required. Removal of the cause will usually end in early recovery. Inattention to the parts may allow the case to proceed to a high grade of inflammation. The first indication is to remove, by means of some bland **soap**—Castile or glycerin soap—and **water**, the foreign elements acting as irritating factors, and immediately afterward dry with a soft towel. An odor may require the addition of a slight quantity of **carbolic acid** or **thymol**.

Bland dusting powders are very useful; but if allowed to remain and absorb the discharges they induce an aggravation. **Boric acid**, **talc**, **fullers' earth**, **lycopodium**, or **starch** in impalpable powder relieves both pain and irritation.

Schamberg recommends in simple cases:

℞ *Magnesiae carbon.*,
Talci venet.,
Zinci oxidiāā ʒij (8 Gm.). M.

Or, the following lotion:—

℞ *Resorcini*,
Acidi borici,
Glyceriniāā ʒj (4 Gm.).
Zinci oxidi ʒij (8 Gm.).
Aquæq. s. ad fʒj (30 c.c.). M.

Solutions are often more grateful, but must be applied almost continuously to obtain good effects. Boric acid in saturated solution is one of the best agents. **Sulphite** and **hyposulphate of sodium** in water in the strength of from $\frac{1}{2}$ to 1 dram (2 to 4 Gm.) to the ounce (30 c.c.) are often beneficial. Astringent washes give excellent results. **Acetate of lead** (3 to 5 grains—0.2 to 0.3 Gm.—to the ounce—30 c.c.—of water), **sulphate of zinc** (1—0.065 Gm.—or more grains to the ounce of water), **acetate of zinc** (in similar proportions), **bichloride of mercury** (1 to 2 grains—0.065 to 0.13 Gm.—to 1000 parts of water), **calomel** (3 to 5 grains—0.2 to 0.3 Gm.—to the ounce of lime-water—*lotio nigra*) are all efficacious. A useful method is to apply one of the above lotions for a period of fifteen minutes; then to thoroughly dry the parts by mopping them, and to follow this by one of the dusting powders. This should be carried out three or more times during each of the twenty-four hours. In addition to the remedial measures the parts must be kept apart by means of medicated lint or cotton: a procedure which suffices in some of the cases observed.

In obstinate cases it may be advisable to place the patient in bed to keep the limbs apart until the acute phase of the trouble disappears.

The treatment of inguinal intertrigo is purely local. Acute cases must be treated like an eczema. Where the surface is inflamed and the epidermis moist and sore, it is best to apply a weak solution of silver nitrate of $3\frac{1}{2}$ per cent. strength; or, if a stronger solution is indicated, one of 10 per cent., the strength being determined by the sensitiveness of the tissues. A very moist, oozing intertrigo is treated each day with a lotion composed of:—

R Argenti nitratis 3j (4 Gm.).

Aquæ dest. ... f3iij (90 c.c.). M.

The use of ichthyol is indicated where the oozing is not excessive and the lesion is red and but slightly moist. A weak solution of ichthyol is used, as in the following prescription:—

R Ichthyoli f5j (4 c.c.).

Resorcini gr. xv (1 Gm.).

Aquæ dest. f3iij (90 c.c.).

M.

A stronger solution contains double the quantities of ichthyol and resorcin. These topical applications are best made with a wad of absorbent cotton. Sabouraud (*La Clinique*, Jan. 22, 1909).

The prophylaxis of this affection consists in keeping the skinfolds scrupulously clean and in the local use of alcohol or iodized or camphorated alcohol.

Where the affection is established the measures suitable are those which will kill the parasitic streptococcus and render the local conditions less favorable to its pullulation. Free use of soap and water is helpful to remove the superficial coccus-bearing skin layers, but the region must be very carefully dried. A better plan is to cleanse the area with alcohol or camphorated alcohol, and this should be done three times daily. Once in each day an application of diluted tincture of iodine may be substituted for the alcohol washing:—

R Tincturæ iodi ʒss (2 c.c.).

Alcoholis 3ij (8 c.c.).

M.

Only in rebellious cases may the pure tincture be applied, and this should be done only once, or, at least, only after an interval of four or five days.

After each alcohol ablation, the area involved should be dusted over generously with sterile talcum powder. Wads of cotton may also be used to keep the adjacent surfaces apart.

The above-mentioned simple measures are generally sufficient. In very obstinate cases, however, the area may be painted every four days, by means of absorbent cotton, with a solution of silver nitrate:—

R Argenti nitratis ʒss (2 Gm.).

Aquæ destillatæ 3x (40 Gm.).

Solve.

The surface should be carefully freed of all fatty material before applying the silver solution. Afterward, a rod of metallic zinc should be passed over the skin. The silver salt becomes reduced thereby, and the silver is precipitated on the affected area, which becomes black. Finally either talcum powder or the following zinc paste is applied:—

R *Zinci oxidi*,
Petrolati,
Adipis lanæ hy-
drosiāā ʒss (15 Gm.).

M. et ft. unguentum.

The preparation is very advantageous in isolating the diseased surfaces, yet permits of evaporation from the skin, by virtue of its porous consistence. The silver nitrate and zinc lead to the action of nascent nitric acid on the tissues, and give rise to some pain. But the results are excellent.

No special diet is necessary in the treatment of intertrigo. Milian (New York Med. Jour., from Paris méd., April 19, 1913). C.

INTESTINAL PARASITES.

See PARASITES, DISEASES DUE TO.

INTESTINES, DISEASES OF THE.—NORMAL AND PATHOLOGICAL PHYSIOLOGY.—

The modern conception of intestinal disorders is so closely bound up with the physiology of the diseased structures that a review of the latter subject is necessary.

It has been well said that we eat with our small intestine and drink with the large. As a result of various factors, foodstuffs are completely disintegrated in the small bowel, and by a process of selective absorption are then taken up by the lacteals. The acid chyme, passing from the stomach into the duodenum, remains acid until such time

as it is neutralized by the intestinal juices, including pancreatic and biliary secretions. According to Cannon, the acid juice of the gastric side of the pylorus, when reaching a certain degree of acidity, acts reflexly, resulting in opening the pylorus, while on the duodenal side its action is the antithesis of this. Further, this acid chyme, by combination with the cells of the duodenal mucosa which contain prosecretin, results in the development of a substance called secretin, which, acting as a hormone, has been shown to be the most powerful excitor of pancreatic juice. This activation, as it is called, of prosecretin cannot be the sole factor in exciting the stimulation of pancreatic juice, because the latter is present even when hydrochloric acid is absent.

Bile, on the other hand, is secreted more or less constantly, but especially during the taking of food and for some time subsequently, during digestion. Toward the end of this period, bile regurgitates into the gall-bladder, probably because of the reflex contraction of the sphincter-like end of the common bile-duct. During intestinal digestion especially bile is discharged into the duodenum, particularly under the influence of proteins and fats. When these gain entrance into the duodenum, perhaps reflexly or possibly by some hormone action, the gall-bladder contracts and the sphincter of the common duct relaxes. Bile was at one time supposed to be antiseptic, but this view is no longer held, for clinically we know the frequency with which the gall-bladder becomes infected in typhoid and other intestinal and general diseases. Bile, too, furnishes an

excellent culture medium. It serves both as an excretion and a secretion. In its excretory function, it aids in carrying away some of the by-products arising in the chemical processes of digestion, while as a secretion it aids in breaking up fats, helping to render them more amenable to absorption. This well-known fact is borne out clinically by the great increase of fat in the feces when for any reason bile is absent. Formerly thought to stimulate peristalsis, it is now known that the chief stimulant to peristalsis occurs purely as a result of taking food, or even the thought of food, when one is hungry, will cause increased peristalsis. As has been stated, with the pancreatic juice it aids in alkalinizing the acid chyme.

The pancreatic juice is by far the most important of all of the secretions concerned in the process of digestion, for it contains all of the essentials, only awaiting activation of trypsinogen in order to be able to digest all of the food substances. The enzymes of the pancreatic juice are trypsinogen, amylapsin, and steapsin. The first of these, trypsinogen, is activated by a secretion of the intestinal mucosa known as enterokinase, trypsin, a proteolytic ferment, resulting. Amylopsin converts starches into sugars, while steapsin is a fat-splitting enzyme. Deficient or absent pancreatic juice also causes the appearance of large amounts of fat in the bowel, allows putrefaction of proteins and fermentation of the carbohydrates, large, pale, pasty, offensive stools resulting. Less is known about the succus entericus in a definite manner, but, apart from the actions already given above, it is

probable that many endogenous enzymes exist, acting only or chiefly within the cells. One of these, also a proteolytic enzyme, is known as erepsin, while another, nuclease, is said to act upon nucleins, while still another, invertase, converts saccharides of more complex forms into simpler ones.

In addition, a certain amount of watery content, epithelial cells, gases, and bacteria are present in the bowel. The large bowel exerts itself chiefly in the direction of absorbing water, which diminishes from about 90 per cent. in the bowel contents at the ileocecal region, to about 75 per cent. in the stools. Some slight absorptive power must exist in the first portion of the large bowel, because small quantities of protein, fats, and sugars may be recovered from the cecum, these being absent from the feces. As the bowel contents move along and absorption of the fluids takes place, they gradually assume a firmer consistency; and except in old people or in some abnormal conditions, only assume form from the position of the splenic flexure downward. Naturally, anything which causes retention for a greater period than normal will result in more or less hardening and scybalous transformation of the contents. Micro-organisms constitute a considerable bulk of the dejecta, the vast majority of which are probably dead at the time of their ejection. According to Strasburger, about one-third of the weight of dried feces consists of bacteria.

X-ray studies have shown that it requires about four and one-half hours for food to traverse the small bowel, which in an adult of average height is about 22½ feet in length,

or at the rate of about 1 inch per minute. In addition to active peristalsis, by which means the food is passed along the bowel, a process of segmentation goes on in the small bowel, evidently designed to expose a greater area of contents to absorption, and at the same time to effect more perfect mixture. From four to four and one-half hours after a meal, food begins to pass into the cecum. Peristalsis is much less active in the large bowel and diminishes progressively along the course of the colon. It has been estimated by Hertz that it requires approximately two hours for food to reach the hepatic flexure and two and one-half hours to reach the splenic flexure and two hours more to reach the commencement of the iliac colon. It may here be stated that the accepted anatomical nomenclature today places the termination of the descending colon at the brim of the pelvis, the iliac colon from the brim of the pelvis to the inner border of the psoas muscle, and the pelvic colon from this latter point to its junction with the rectum at the angulation opposite the third sacral segment. With this in mind, one may better understand Hertz's statement that the rate of passage through the iliac colon is about equal to that through the preceding portions of the colon, but that through the pelvic colon (formerly known as the sigmoid or omega loop) the rate is much slower, and that normally nothing enters the rectum until the stimulus to defecation is received.

It is probable that segmentation, as it is known in the small intestine, never occurs in the large, and anything approaching to the peristaltic movement of the small bowel never

occurs in the large. It is possible that the waves are too small to be perceptible on a fluoroscopic screen.

A point of interest and value in diagnosis is the relation between gastric and intestinal sounds, which occur normally and are more or less rhythmical and musical than the sounds heard over the ileocecal valve. This valve, or the valve of Bauhin, like the internal rectal sphincter, is formed by an increase of the muscular coat of the bowel. The transverse layer of the ileum is more or less thickened at its point of entrance into the colon and constitutes the ileocecal valve. It is kept in a state of moderate tonic contraction through impulses conveyed by the splanchnics. Hence, stimulation of these nerves, as in appendicitis or peritoneal inflammation, causes firm contraction of the sphincter, and at the same time inhibits movements of the intestines more or less widespread. The bowel contents are thus prevented from passing into the cecum; all cecal sounds cease if the process be a local one, as in appendicitis, and with general inhibition, as in diffuse peritonitis, all sounds may cease (see F. Hertz: "Abdominal Auscultation as an Aid in Diagnosis," *Brit. Med. Jour.*, 1908, vol. ii). The contractability of the gastrointestinal musculature, however, is not solely under the control of the cerebrospinal and autonomic nervous system, for, like the heart muscle, a certain amount of automatic rhythmical movement is possible, as shown in excised portions. It is probable that these motor functions, independent of the central nervous system, are to be attributed to the nerve cells constituting the plexus of Auerbach. Normally, stim-

ulation of the vagi causes contraction of the stomach and bowel muscles, except those of the colon, these latter being under the control of the pelvic nerves, coming from the sacral cord.

INTESTINAL NEUROSES.

It has been previously stated that the gastrointestinal functions are excited both psychically and by the taking of food, and abnormally too; disturbance of functions may result in consequence of various psychic factors as well as from improper foods or beverages, or excessive amounts of these. Consequently, various intestinal symptoms may in all justification be ascribed to functional neuroses, or to reflex disturbances from near or remote points, and it is believed that even changes in the amount or quality of the various enzymes and even their suppression may result from psychic factors. Intestinal neuroses may be grouped under three subdivisions: (a) Motor. (b) Sensory. (c) Secretory.

A. MOTOR DISTURBANCES.

—As we have seen, active peristalsis is practically limited to the small bowel, and, therefore, since this is supplied by the vagus, increased motility presupposes vagal irritation from some source, while the converse of this, namely, deficient motility, is the result of splanchnic irritation. By motor disorders of the bowel we imply, therefore, functional disturbances solely concerning the vagus.

Increased motor activity is termed peristaltic unrest, and, while it frequently results from the presence of irritants of various kinds, it is often due to psychic disturbances, as in nervous, hysterical, emotional, or hy-

pochondriacal states. In their mildest form, borborygmi constitute the chief evidence, which in the hysterical, as is well known, may be loud enough to be heard many feet from the patient, and often associated with contractions of the abdominal muscles, rhythmical in character. Pain is the exception in this state. Eructations, sometimes explosive, and even violent, may be associated. When still more marked, pain may result, tormina, in consequence of the peristalsis which in thin individuals may be observed through the abdominal wall.

Nervous diarrhea is a combination of peristaltic unrest plus an increased transudation of fluid into the bowel. Either one of these factors may predominate, so that in some instances the condition is painful, while in others watery diarrhea is the chief factor, without pain. This is sometimes spoken of as a diarrhea of relaxation. Mental disturbances, such as worry, shock, fright, or emotional states of various kinds, not rare in students before examination periods, when the vesical sphincter is also subject to relaxation, are illustrations of its possible psychic types, as are those cases dependent upon fancied or real genitourinary conditions. The taking of hot or cold beverages may also act as a stimulant, with the production of diarrhea shortly after the beverage is taken; as an evidence of motor disturbance of organic origin may be cited locomotor ataxia or transverse myelitis or a meningo-myelitis. This possibility necessarily depends upon the site of the lesion, and, as a rule, retention prevails, though in other instances involuntary diarrhea may be the conse-

quence. In the purely functional states loose stools vary from one to many, consisting of watery material, not unduly offensive, usually without evidence of mucus, rather serous in fact, with more or less gurgling sound.

Intestinal Spasm.—This has already been touched upon in speaking of peristaltic unrest. In its milder forms diarrhea is the rule; but in lead poisoning, enterospasm and constipation are associated. In cerebral meningitis associated with a gradually developing scaphoid abdomen diarrhea may first appear and obstinate constipation later. It is never a very marked manifestation in the purely functional conditions.

Intestinal Paralysis.—As was stated under the physiological heading, this frequently occurs as a result of splanchnic irritation, in which case the ileocecal valve contracts, while the intestinal movements are inhibited. This accounts for the quiescent state of the stomach and small bowel during abdominal operations, exposure to air resulting in temporary inhibition. It may also occur after operations during which the viscera have been freely handled. In some measure this inhibition of movement is beneficent, for when perforation occurs inhibition lessens to some extent the spread of peritoneal contamination. The colon is supplied by the pelvic nerves and is not associated with the sympathetics. Any condition lowering the general neuromuscular tone, as in disorders of the brain or cord, typhoid states, on the one hand, or focal lesions on the other, may result in muscular paresis of any portion of the bowel, including the rectal sphincters, so that event-

ually involuntary discharges may occur.

TREATMENT.—The treatment of motor neuroses will depend, of course, on the causative factors and on the extent of the symptoms. In the milder psychic cases isolation is not necessary, but it is certainly an indispensable adjunct in the more marked types, and is sometimes imperative in cases of actual mental derangement. Great caution should be exercised in the employment of narcotics in any of these conditions, for the habit is readily established.

Since insomnia is so frequently associated with nervous conditions, attention to this detail is indicated, for its persistence aggravates the nervous symptoms, which in turn aggravate the insomnia. **Hot baths** at bedtime, or preferably 5 grains (0.3 Gm.) of **Dover's powder**, followed by a **cabinet sweat bath** and after the cabinet sweat a **sponge with warm water and soap**, will often effectually obtain an unbroken rest, and at the same time relieve the diarrhea. In cases associated with muscular spasm, **atropine**, **belladonna**, and **hyoscyamus** are of value rather than morphine and eserine salicylate in the atonic cases. Occasionally in the most marked spastic cases, **opium** in some form may be necessary to relieve the spasm and constipation attendant upon it.

B. SENSORY DISORDERS.—Some of these have already been touched upon, since they are the inevitable result of the more marked types of motor disturbances. The intestine and its peritoneum are devoid of ordinary nerves of sensation. It is possible that they possess some protopathic sensory function, but even

this is not certain. Mackenzie seems to have shown that pain emanating from intestinal disturbances is really referred to the abdominal wall, and that it represents a visceromotor reflex originating in stimulation of the autonomic fibers. Neither handling, cutting, nor burning of the intestine experimentally seems capable of exciting pain sense, but distention or obstruction, either of which interferes with the normal passage of the peristaltic waves; these seem to be the only stimuli capable of awakening pain not only in the case of the intestine, but also of the other hollow muscular viscera, as the stomach, ureter, renal pelvis, bile-ducts, etc.

Intestinal pain or *enterodynia*, therefore, always follows distention produced either by gaseous decomposition and accumulations within the lumen or from some form of obstruction to the peristaltic wave. When this becomes still more marked and paroxysmal, we speak of it as *colic*. As we have seen, the splanchnics preside over the bowel in a peculiar manner, bringing about inhibition of the general bowel wall, except the colon, with closure of the ileocecal valve. Many of the stimuli, therefore, emanating from within the bowel are probably not felt because of this influence, the irritation not having been sufficient to excite visceromotor reflexes. We have also shown that peritonitis, too, may be limited by these means. Painful stimuli do not arise in peritonitis, unless the parietes are involved and then only because of the distribution of visceromotor nerves in the peritoneal tissue.

TREATMENT.—In the functional sensory disturbances relief is often

obtained by local application to the abdominal wall, thereby obtunding visceromotor reflexes, excited through spinal irritation carried from the bowel afferently by the splanchnics. These with the employment of some carminative, such as **chloroform**, 2 drops; **spirit of camphor** and **Hoffmann's anodyne**, of each, $\frac{1}{2}$ dram (2 c.c.), together with some mild laxative. Fright, fear, excitement, or, in short, any psychic disturbance must necessarily be dealt with according to its merits.

C. SECRETORY DISORDERS.—

It seems probable, in view of the watery diarrhea that follows psychic disturbances, with or without evidence of sensory disturbances, that in some instances these are due solely to the emotions. It is probable that normally a stimulus results with the production of sufficient fluidity to prevent the stools from becoming scybalous, or, because of neglect, obtunding of the parts and prolonged contact with the mucosa result in abnormal drying of the contents. The only two conditions which with any degree of justification can be looked upon as functional disorders of a secretory character are, first, serous diarrhea, and, second, mucous colitis. With the former of these we have already dealt.

MUCOUS COLITIS.

SYNONYMS.—Mucous colic, tubular diarrhea, mucomembranous colitis, and myxoneurosis intestinalis.

DEFINITION.—In the strict sense in which the terms mucous colitis or membranous colitis are employed here, we are dealing essentially with one of the secretory neuroses of the colon, characterized by more or less

frequent stools, often very painful, containing tough mucus in shreds and masses and occasionally tubular structures composed of epithelial cells of mucosa, together with more or less mucus. In some, constipation alternating with diarrhea exists.

SYMPTOMS.—The vast majority of patients presenting this condition are women, and they range themselves into two groups: first, those of a more or less chronic dyspeptic and melancholic type, not seldom of constipated habit, and the other, high-strung, active, extremely nervous, intensive and often imaginative individuals who most commonly suffer with diarrhea. The former, and less frequently the latter, group may also have visceroptosis, though this is not an essential part of the picture. As a rule, the sufferers from this condition are usually somewhat ill nourished, though occasionally one meets with a well-developed woman, especially, in whom, following some domestic or other trouble, the condition develops. The dyspeptic type of cases are those, as a rule, who quarrel with their food, so to speak, finding fault with one article of diet after another, until after a process of elimination they virtually starve themselves; in consequence of this their nutrition suffers, they lose weight, complain of the cold, are subject to chilly sensations, and insist on wearing a great deal of clothing. More or less anemia is the rule. Though constipation prevails in this type, an occasional attack of diarrhea may ensue without apparent cause, and the breath is often somewhat offensive, mouth rather dry, tongue coated, and after some special nervous strain quantities of mucus will be passed, less frequently of the

tubular variety than is the case with the irritable, high-strung type. So, too, with vesical symptoms.

In the melancholic type frequency of micturition and more or less dysuria are rather uncommon. From time to time, they suffer attacks of abdominal pain, colicky, griping in character, often with tenesmus with some meteorism and tenderness on pressure, over the outer part of both iliac regions especially. Nausea and vomiting are uncommon. Though the mental depression is almost constant, the abdominal symptoms are intermittent, and some time may elapse without definite evidence of a mucous colitis, when rather suddenly, following colic, masses of glairy mucus and even pseudomembranous material may be passed. Internal hemorrhoids not seldom occur in these individuals, and in such instances large amounts of blood may be lost, rendering the patient more or less acutely anemic. Such cases, in the absence of the colitis stage, usually have hard, scybalous movements, or both this and the passage of jelly-like mucus. Owing to the severity of the tenesmus in some instances syncope attacks may occur during the attempt at defecation. Digital examination of the rectum and even the use of a proctoscope or sigmoidoscope may reveal nothing abnormal, or at most some hemorrhoids. It seems as though cycles existed during which volumes of mucus are poured out, and this passes almost immediately.

The more actively high strung, neurotic type presents a somewhat different aspect, often voluble, readily subject to irritation and often proving very irritating in social relations

with others, verbose and frequently quarrelsome, often of a subtle and suspicious type, harboring real or imaginary grievances and not seldom possessed of sexual neuroses. In this type the dyspeptic symptoms are not marked. The appetite is often good, sometimes even large, but capricious.

Diarrhea is the prevailing feature, and as many as 15 or 20 stools a day may be suffered without evidence of more prostration than would follow but 2 or 3 movements. Tormina and tenesmus are often very marked, bloody mucus is not uncommon, and in the case of internal hemorrhoids the passage of large quantities of blood. The most striking feature, in this type especially, is the passage of membranes or skins, as they are often termed by patients, which may be pale or more or less brown, as a result of staining by bowel contents. In the most marked cases it forms a complete cast, tubular in shape and varying in length from one to several inches, rarely longer. They may be very thin, and their true shape only discovered by floating out, preferably in salt solution, or very thick and tough. Either with this, or more frequently without, pieces and shreds of all shapes and sizes may be voided, or ball-like masses held together by glairy mucus may be passed. Teased out under the microscope, they are found for the most part to be structureless, though containing fragments of more or less digested material, micro-organisms, phosphates, and occasionally cholesterin crystals. Here and there columnar epithelial cells may be seen, or long, continuous shreds of epithelium, often very well preserved, constitute the bulk of the cast.

Except for the conditions stated, the general body functions may be apparently normal, at least as far as any physical examination or laboratory test is able to reveal. If psycho-analytic methods be employed, it will often be discovered that these individuals have a mental bias dependent upon some worry or trouble connected with their daily life. It is probably safe to assert that fully one-half of the women have some diseased condition of the uterus, tubes, or ovaries, or that the sex relation is of an abnormal or depressive type.

[I know of one instance in which the dread of pregnancy became a monomania, and this woman had a most marked mucous-membranous colitis with 15 to 20 stools daily, often exquisitely painful, associated with internal hemorrhoids and the loss of much blood. Clamp and cautery operation, done by Dr. Lewis H. Adler, had no other effect than causing a cessation of the bleeding. She had suffered a number of miscarriages, some doubtless induced, and on account of the intense suffering at the menstrual periods, together with the reflex pains at other times, ovaries and tubes were removed by Dr. Duncan. For some time subsequently the mucous colitis ceased, but recurred later. Without local manifestations, certainly without evidence of appendicitis, I suggested an appendectomy and the performance of an appendicostomy with subsequent irrigation of the colon. This was done by Dr. Wayne Babcock almost three years ago, since which time the patient has gained a great deal of weight and has been absolutely symptom-free as far as the colon is concerned. W. EGBERT ROBERTSON.]

Membranous dysmenorrhea is said to occur in a small proportion of these cases, but such a case has never come under my personal observation. Intestinal sand, too, of the true variety is not infrequent in this type of patient, which consists chiefly of phosphate and oxalate of calcium

with iron and magnesium with biliary coloring matter. These are usually the more severe types.

[Another case under my observation, one of the depressive type, developed after the advent of infelicity, following a childless union. Dilatation and curettage, and abdominal section with resection of the ovaries, failed to have any influence upon the condition. The woman markedly improved, however, after separation was effected and she devoted herself to social service work. R.]

Mucous colitis is a symptom of a number of different diseases of the colon of widely different characters. In 36 cases observed by the writer diarrhea was a prominent feature in the majority of cases, and in some it was most severe. A definite inflammatory condition of the mucosa was found in 24 cases. Ulceration was present in 7 cases. Mummery (*Lancet*, June 15, 1907).

Epidemic of croupous enteritis with a tempestuous onset with fever, leucocytosis, rapid pulse, violent colics, blood-stained stools and tenesmus, and speedy fatal termination. Ten cases are reported with autopsy findings; a pseudomembrane had developed at points in the small or large intestine, or both, and streptococci were found in overwhelming numbers. Beermann and Eckersdorff (*Münch. med. Woch.*, June 8, 1909).

DIAGNOSIS.—Since mucous colitis and even the passage of pseudomembranes may occur as a secondary process due to some organic factor, it is important to make a careful physical examination, including a painstaking digital examination of the rectum and a bimanual vaginal examination, and in competent hands, the use of the proctoscope and sigmoidoscope should be practised. The recognition of types in which this essential functional neurosis is most apt to occur is of extreme importance.

Care should be taken also to avoid mistaking vegetable cellulose, as when asparagus is eaten or the skins of sausage, for mucomembranous material.

Mucous colitis seldom exists alone, but is merely a local expression of a general catarrhal tendency involving all mucosæ, a polymyxoditis. There occur elevations of temperature which have a notable intermittent character at times, appearing as quotidian, tertian, quartan, or even with remissions of a week. As a rule, rigors and sweats do not occur, and the rise does not exceed 38° C. (100.4° F.). The condition persists until the colitis is cured. Couto (*Deut. med. Woch.*, April 17, 1913).

During the last 5 years the writer has had under observation in hospitals and private practice 870 cases. He found the disease in 3 distinct groups: Simple mucous colitis, mucomembranous colitis, and mucomembranous colitis with visceroptosis. The first group is easily mastered; the 2 other groups are more resistant due to the severe accompanying disturbances. The affection is often mistaken for hysteria, neurasthenia, gastric neurosis, syphilis, ovarian or uterine disturbance, or movable kidney. Capparoni (*Policlinico*, Nov. 5, 1916).

ETIOLOGY.—Sex is the most important factor. It is usually stated that fully 80 per cent. of the cases occur in women, but I should be inclined to regard this as too low. I have never seen an authentic case in a male, though, of course, it is conceivable. Age, too, is important and likewise suggestive, for the majority of cases occur during the period of active sexual life, from 20 to 40, and are exceedingly rare after 50.

Mucomembranous colitis occurs four or five times more frequently in women than in men. It generally begins between the ages of 20 and 45, but the writer has seen it in a child

of 3, and in Goodhart's experience it is by no means uncommon in children, as he has several times seen perfect mucous casts of the intestines passed by them. A. F. Hertz (*Clinical Jour.*, Aug. 3, 1910).

When an apparent case develops in one over 40, and even more so in later years, an organic cause should be sought for most carefully. Cases have been recorded in children, but they are open to suspicion, for it is questionable whether they are of the type comprised under the caption of myxoneurosis intestinalis. Neurotic and hysterical women or less often, women of the depressive, melancholic type, are those in whom it is almost solely found.

An X-ray study of mucous colitis showed malpositions and angulations of the colon which were coincident with more or less characteristic attacks of the disease. C. C. Fihe (*Ohio State Med. Jour.*, Oct. 15, 1911).

In a series of 625 cases G. D. Kahlo reported 78 cases of appendicitis. Alfred Mantle, of London, says that intestinal surgery has shown that the mucous membrane of the colon and the appendix may be simultaneously affected, and that, after a thorough investigation of many cases of colitis, mucous colitis is not infrequently an antecedent of appendicitis. A. E. Benjamin (*Journal-Lancet*, July 15, 1913).

The writer observed 3 cases of mucous colitis which were relieved by removing dental and nasopharyngeal foci. J. W. Preston (*Jour. Amer. Med. Assoc.*, Nov. 27, 1915).

PATHOLOGY.—There is really no morbid picture. It is not an inflammatory disease, and no characteristic change occurs in the intestinal wall.

PROGNOSIS.—It is not a fatal disease, but frequently very persistent, many being absolutely rebellious

to all of the commonly employed plans of treatment. It often lasts for years and the more chronic the more rebellious.

TREATMENT.—A thorough study should be made of the patient as an individual. A searching inquiry should be made into the daily routine, and indeed into every phase of the patient's life, precisely as it is necessary in any case with a nervous substratum. Great care should be exercised in dealing with the patient in a kindly, forcible, but always consistent manner, and the avoidance of any semblance of morbid suggestion should be strictly adhered to, and especially an effort should be made to unravel the events immediately preceding the development of the condition. This may sometimes throw light upon the psychic side. In the intervals between the attacks the patient should be encouraged to live, as far as possible, a healthy and sane existence, indulging in fresh air, as much exercise as possible, and in an ample dietary.

The diet need not be restricted, even in an attack, though, of course, cellulose and all indigestible materials should be eliminated. Without especially seeming to do so, an attempt should be made to gratify the patient's appetite, avoiding an excess of sweets and any whims which may be manifested. Regular meals and plenty of rest should be obtained.

Von Noorden's treatment is essentially one of diet, but in place of the usual bland, unirritating diet with little residue, recommended by some, von Noorden advocates a coarse laxative diet, leaving as large a residue as possible. He prevents the usual irritating effect of such a diet by add-

ing to it large quantities of fat in various forms.

The most important element in his diet is cellulose, obtained from vegetables and the husks of various leguminous plants. The cellulose undergoes bacterial decomposition in the intestine, and so gradually that the binding together of the feces into solid, hard lumps is prevented.

The patient should go to bed and stay there. A rubber **hot-water bottle** is to be placed on the **abdomen** whenever there is distention or pain, and at night an **enema** of 6 to 10 ounces (180 to 300 c.c.) of **olive oil** at a temperature of 98° F. (36.7° C.) is given slowly from a douche-can with a long, soft-rubber nozzle (8 inches), preferably in the genupectoral position, or on the back with raised hips.

A **suppository of belladonna** extract (gr. ss—0.03 Gm.) or of **morphine**, if the pain is severe, should be inserted, and the patient directed to retain the oil until morning. It may be necessary to continue the oil injection and belladonna suppository for several days. Ransome (Liverpool Medico-Chir. Jour., July, 1908).

Two cases of obstinate mucous colitis, rebellious to all known treatments, which responded promptly to the oral use of **charcoal**, given 4 times daily, after meals, in doses of 8 Gm. (2 drams) suspended in water, or enclosed in cachets. T. B. Broadway (Lancet, May 4, 1918).

Insomnia, not an uncommon feature of this disease, requires very careful handling. The possible acquisition of the drug habit can be readily foreseen. Where possible, change of scene is often beneficent, and if their interest in any legitimate occupation can be encouraged, the battle is often half-won.

The writer prefers **castor oil**; aloin is apt to cause enterospasm, and salines are uncertain where atony of the colon exists; **calomel** is useful in occasional doses which should be small— $\frac{1}{10}$ to $\frac{1}{8}$ grain (0.006 to 0.01

Gm.). He advises against the employment of massage in cases where pain and enterospasm are prominent features. Authorities are not agreed upon the subject of **diet**, but the writer believes that one leaving but little residue is to be preferred, and that in severe cases it should be purely lactofarinaceous. As to the question of surgical measures, he has seen great improvement in 3 cases from **ileosigmoidostomy**, though in none complete cure. This operation will prove more satisfactory than appendicostomy, and the writer would never hesitate to recommend it in cases which had resisted all other methods of treatment. R. Hutchison (Clinical Journal, July 10, 1907).

The **crude tar** sold by ship chandlers (**Pinus palustris**), mixed with flour as an excipient and placed in No. 2 capsules, two or three being taken about one hour after meals, acts as a laxative and relieves the obstinate constipation, the pain in the abdomen, and tenesmus very speedily. A complete cure can be obtained in from four to six weeks. David Wark (Med. Record, Sept. 5, 1908).

The use of **agar-agar** has greatly simplified the **diet** problem in these cases, for, even when the patient is taking bland food, the addition of from 2 to 4 teaspoonfuls of agar-agar, daily, causes the stools to become soft and bulky. Storck (Monthly Cyclo. and Med. Bull., Oct., 1910).

Apply to abdomen at night a towel soaked in **magnesium sulphate solution**, $\frac{1}{2}$ ounce (15 Gm.) to 1 pint (500 c.c.) of water, at 75° F. (23.8° C.). Irrigate the rectum with 2 gallons of the same solution at 85° to 90° F. (29.4° to 32.2° C.). The mucus disappears, and pain and gas formation diminish. Milk **diet**, with fruit, especially grapes, is also effective; $1\frac{1}{2}$ quarts of milk to be taken during the day and 1 pint of hot milk at bedtime; continue for ten days to two weeks. Wark's crude **Pinus palustris** treatment gave good results. Joseph (Vt. Med. Mthly., Oct., 1911).

Calumba-agar, containing solid constituents of 2 c.c. (32 minims) of fl. ext. calumba in 1 Gm. (15 grains) of agar, found useful in mucous colitis. Einhorn (Amer. Jour. Med. Sci., Feb., 1912).

All sorts of enemas have been employed, with about an equal degree of failure. Not seldom they result in a degree of local irritation which positively contraindicates them.

The **Tivoli douche** consists of an ordinary reclining bath, in which the patient lies covered, except for the head and neck, in warm mineral water. While so lying a hot-wave douche is played on the abdomen; this latter is usually of a much higher temperature than that of the bath. These methods are carried out in conjunction with special **dieting** and the drinking of **mineral waters**. Technique is that employed at the springs of Harrowgate, England. Wilson (Edinburgh Med. Jour., vol. xxii, 45, 1907).

Treatment by **irrigation of the colon**, as carried out at Plombières and Harrowgate, gives excellent results. It consists of irrigation of the bowel by a hydrostatic douche, given through a long tube passed into the sigmoid. Twenty to 40 ounces of alkaline sulphur water at a low pressure are used. After the interval douche follows a warm immersion bath of **sulphur water**, a hot douche playing upon the wall of the abdomen from a large nozzle with small perforations directed over the site of the colon. Attention, on the patient's part, to **moderate exercise**, **warm clothing**, the use of a **hot bottle** to the **cold extremities**, and avoidance of exposure to undue cold will give the greatest comfort, and by attracting blood from the splanchnic area to the periphery relieve the affected bowel. Care in **diet**, avoiding all articles of food which may irritate the mucous membrane, must be strictly enforced. Mantle (Brit. Med. Jour., July 11, 1908).

In **lavage through the appendix** normal **saline solution** or a 5 per cent. **glucose** should be used, as the least irritating of lotions. In some cases if 1½ (750 c.c.) or even 2 pints (1000 c.c.) of saline are passed through the appendix it works along the bowel and distends the sigmoid, but it is not expelled spontaneously. Sometimes gentle massage over the colon leads to its expulsion, but in other cases this fails. In such cases it may be necessary to use astringents; of these the mildest are employed—**hazeline**, **zinc sulphate**, a few drops of **formalin**, or the smallest quantity of **silver nitrate**, either of which generally leads to a spontaneous evacuation.

Hawkins and Mummery both use **olive oil** to remove the mucus. The writer prefers **liquid petrolatum** rectally. Daniel (Proctologist, Mar., 1912).

The writer employs pills of **dry pancreatic extract** and **sodium bicarbonate** (2 to 1), sometimes with **bile** as an excipient. Savini (Arch. des mal. de l'app. digestif et de la nutrition; Med. Record, Feb. 9, 1918).

In those instances in which a pelvic factor seems to be at work operative interference occasionally effects a cure, and in a goodly proportion of cases an **appendectomy** will be followed by a restoration of health, but I would advocate the more extensive employment of **appendicostomy** with subsequent **intestinal lavage** through the stump of the appendix, and after the recovery of the patient, which follows as a rule, it is not difficult to heal the minute sinus by the applications of a 33⅓ per cent. solution of **zinc chloride**, using a very fine cotton applicator.

Report of 27 cases of mucous colitis cured by the operation of **lateral anastomosis of the ileum and the sigmoid**. All the cases were bad ones, and with few exceptions were poorly nourished, anemic subjects, often suffering from atonic dilatation of the

stomach, achylia, pyloric insufficiency, enteroptosis, and various pelvic lesions. Of the 27 cases, 18 now have evacuations of bowels from one to three times daily without laxatives. The relief of colicky pains was remarkable. Some recovered in a few weeks and others gradually improved. Tenderness and soreness also disappeared after the effects of the operation cleared up.

The operative procedure is based on the principle that mucous colitis is largely attributable to putrefaction and decomposition. The first object of the anastomosis is to drain the most intensely infected section of the ileum, preventing its discharges into the cecum, for the amount of decomposition, irritation, and absorption of toxins is in proportion to the quantity and character of material entering the colon.

The anastomosis was made as low down in the ileum and sigmoid as the two portions of the intestinal canal could be approximated without tension. Loops were drawn out of the abdomen far enough to make the work easy and satisfactory. G. H. Noble (*Amer. Jour. of Obstet.*, March, 1910).

INTESTINAL CATARRH.

SYNONYMS.—Intestinal inflammation; duodenitis, enteritis, colitis, proctitis, enterocolitis, according to the parts chiefly involved. The term diarrhea is also employed, as in the majority of instances this is the chief characteristic of the morbid condition.

DEFINITION.—Inflammation of the mucosa, hence catarrh, of any portion of the intestinal canal. It is not possible to recognize clinically the anatomical seat of the disease, with the possible exception of duodenitis or gastroduodenitis, as it usually is enteritis, colitis, and proctitis. Any part or all of the canal may be involved as an acute or chronic process, primary or secondary.

SYMPTOMS.—Acute Form.—In the simple acute form of catarrhal enteritis or diarrhea, mucoenteritis, colicky pain in the abdomen, and diarrhea are the chief features. Diarrhea may occur in the absence of intestinal inflammation as the result of nervous relaxation, a secretory neurosis, and, on the other hand, actual inflammation may exist without diarrhea, as in cases of duodenitis or jejunitis, but the association of both diarrhea and colicky pain bespeak an enteritis. If to the griping pain or tormina tenesmus be added, we are also dealing with a colitis or proctitis or both. The diarrhea is due to the inflammation of bacterial origin or, in part, to mechanical causes, as from improper foodstuffs and the resulting increased peristalsis.

The stools, at first fecal, dark in color, black or green, become lighter, even a dirty white, depending on the amount of biliary coloring matter. In consistence they vary from a watery to a gruel-like material, with flakes of mucus more or less incorporated when the small bowel is chiefly implicated. Microscopically they will be found to contain crystals—calcium oxalate and phosphate, Charcot-Leyden, and ammoniomagnesium—epithelial cells (columnar) and mucus, rarely cholesterolin plates and vast numbers of micro-organisms. A few red blood-cells may be found in the very severe forms and the occult reaction may be positive, even when no free red cells are observed. The other food remnants, present in greater or less numbers, plant cells, meat fibers, and starch, are usually alkaline in reaction.

Tympanites and borborygmi occur

whenever intestinal decomposition is going on. There may be very little tendency to an increased number of stools, or, again, there may be 10 to 20 in twenty-four hours. The lighter-colored stools are often very offensive. When vomiting occurs it is an acute symptom. Fever is slight and transient generally. The appetite is lost, the tongue coated and dry, and thirst is pronounced. Prostration is often disproportionate to the duration and apparent severity of the attack; it is probably toxic in origin, as are the headache, albuminuria, and body pains.

Duodenitis.—In this condition diarrhea is the exception, moderate constipation and jaundice being the dominant symptoms of a developed attack. In the earlier stages the symptoms are usually gastric, nausea and repeated vomiting, as a gastro-duodenitis is the morbid entity. In the absence of catarrhal swelling of the common duct and consequent jaundice, there is nothing diagnostic about the attack. A sense of epigastric distention, slight epigastric tenderness, a little quickening of the pulse rate, rarely an occasional cardiac arrhythmia, coated tongue, foul breath, and slight fever for a few days.

Jejunitis and Ileitis.—This is not to be separately diagnosed, but it may be suspected when the diarrhea (a common feature) is lienteric. Borborygmi, tympany, pain in the abdomen, especially in the region of the umbilicus, and undigested food particles in the stools, which in the absence of a duodenitis always contain bile and pigmented mucus, constitute the chief features. Colitis is very frequently associated with ileitis, and

tenesmus is apt to become the most marked and painful phenomenon.

Colitis.—Tenesmus and considerable glairy mucus with small and frequent stools and more or less constant desire to move the bowels constitute the important features of this state, and these are even more marked, the suffering being greater when the rectum is also involved. It is not unusual for an attack to begin in the small bowel, then involve the colon, and terminate as a proctitis which is often more lasting and rebellious to treatment. In colitis the tenderness is most marked down low in the abdomen, below the transverse umbilical line, and blood and mucus are frequently intermixed and grossly evident. The mucus increases in amount as the bowel is involved from above downward.

Proctitis.—Inflammation of the rectum. In this condition mucus or mucopus in large quantities is often passed without fecal material, and frequent calls to stool—almost constant, in fact—with distressing tenesmus constitute the diagnostic features. It must not be forgotten that this condition may be secondary to perirectal inflammation.

Chronic Form.—Chronic catarrh of the intestine is usually secondary to the acute or may occasionally arise without the preceding acute symptoms. It is the rule in portal congestion from any cause. The same features occur as were noted above, but pain is less, even absent in some cases. The most striking feature is the disturbance of nutrition due to the more or less prolonged course—loss of weight, anemia, and in many instances mental depression, low spirits, hypochondriasis, or melan-

cholias. Constipation alone or alternating with diarrhea, as a rule, and fermented, gaseous, offensive stools are to be noted. Fever is practically absent.

Chronic enteritis observed in 9 patients. The symptoms were intense intermittent colic, vomiting, and mucous stools; temperature and pulse usually normal; visible peristalsis above area of obstruction; progressive emaciation, with no improvement under expectant treatment. The abdomen was opened in each case and more or less bowel found similarly affected. Its surface was smooth and the walls rigid and thickened. Coliform bacilli were isolated from one specimen, but the others showed only the ordinary intestinal flora. T. U. Dalziel (Med. Rec., Aug. 16, 1913).

In the chronic enteritis of amebic cases there may occur, apart from functional disturbances of the colon, symptoms due to dragging on the abdominal sympathetic, in particular the filaments from the solar and celiac plexuses, through the mesentery. They consist of discomfort, weight, dragging, and squeezing, referred chiefly to the lower epigastric and paraumbilical regions. At times the discomfort amounts to actual pain, accompanied by a profound malaise which reacts heavily upon the mental equilibrium of the patients, generally deeply affected when the disturbance is of long standing and marked loss of weight has occurred. While aerophagia and the resulting dyspeptic disturbances are rather frequent, the stomach should not be held to account for the symptoms just referred to. E. Deglos (Paris méd., July 13, 1918).

War Enteritis or Trench Diarrhea.—As stated by Remlinger and Dumas (Rev. d'hygiène et de police sanitaire, Mar. 20, 1915), the term includes different conditions: Infections by typhoid and paratyphoid bacilli, muco-membranous enteritis, diarrhea connected with improper action of the stomach. In most cases it is

simply a more or less acute form of dysentery—a complaint from which no troops in the field are exempt. Diarrhea and dysentery have prevailed with particular severity among the troops in the Argonne. They appeared at the end of the hot weather, when hostilities began in that district, and were but little checked by the cold of winter. Of the several hundred cases, some were dyspeptics of long standing, others were cases of muco-membranous enteritis, easily produced by the coarse army diet, consisting largely of meat, independently of any stay in the trenches. Another was a case of paratyphoid.

Trench diarrhea, according to Remlinger and Dumas (*Ibid.*), has been attributed to cold and wet, and to the want of warm food. In the case of the large numbers of men unaccustomed to much meat, the fact that the rations consist almost exclusively of beef was certainly a contributory cause. Few of the patients attributed their malady to water. Although a few admitted they had drunk water from shell holes or from sources of doubtful purity, most of them said that the cold enabled them to a large extent to do without drinking anything but wine, tea, or coffee.

The authors look upon all these causes as predisposing only. The special bacillus seems, however, to have little effect alone, having been found in the feces of men who have not been exposed to the predisposing conditions, and who had remained in perfect health. The pathogenic bacilli seem to be derived from the trench mud contaminated with feces. This gets onto the boots, thence onto the hands and the food. In the summer dust and flies also transmit the infection. Even if the latter does not occur in the trenches, it may take place in the neighboring villages where the men go to rest, after 5 or 10 days in the trenches. The result is that these villages being crowded and deprived of proper sanitary precautions, even here the food may become contaminated.

DIAGNOSIS.—Attention to the degree of temperature, the presence or absence of jaundice, acute or chronic nature of the attack, frequency and character of stools as to food particles, mucus or mucopus,

and blood, tormina or tenesmus or both, and the degree of nutritional disturbances are the chief clinical features as outlined above.

From typhoid fever the diagnosis is to be made by the Widal, diazo, and Russo reactions, possibly by the leucocyte count and blood-culture. From dysentery, by the greater severity and usual acuteness of the illness and the bloody stools in that disease. In lead colic the occupation or other possible source of lead poisoning elicited in the history, the blue line on the gums, obstinate constipation, relief of pain by pressure and the basophilic red cells.

In amyloid disease of the bowel, evidence of chronic suppuration—tuberculous, as a rule—or of an old syphilis will serve to make recognition possible. Cholera morbus and intestinal ulcers are not likely to obtrude as diagnostic difficulties.

ETIOLOGY.—The various forms of intestinal catarrh may be due to primary or secondary causes. Primary—(a) Overeating. This is mechanical and excites peristalsis. (b) Improper foods. These may act as local irritants because of an idiosyncrasy or because of local irritations, as is the case when unripe fruits are eaten. (c) Toxic substances. When spoiled foodstuffs are ingested, usually milk, ice cream or meat, or certain of the inorganic poisons, as arsenic or mercury. (d) Weather conditions. The nature of which is unknown, though it is not unusual to observe a local outbreak of diarrheal disorders. In institutions these are not rarely due to one of the forms of the dysentery bacillus. A sudden change in the weather, or the heat of summer, is especially

prone to invite the disease. (e) Impure drinking water or merely a change of water will sometimes induce an attack. (f) Nervous states will cause diarrhea in some individuals. (g) An excessive amount of bile may conceivably cause diarrhea by exciting peristalsis, but the recognition of such a case from the clinical standpoint would be speculative.

Report of an epidemic of mild diarrhea occurring in nearly every one of 18 members of a large household. Investigation showed that for some time the meats and other food kept in the larder had been affected with a pinkish growth, which on examination was found to be the *Bacillus prodigiosus*. Parkes (Brit. Med. Jour., Nov. 18, 1905).

Report of an epidemic of diarrhea affecting 472 of 1235 soldiers during maneuvers. The symptoms ranged from those of ordinary enteritis to a syndrome resembling typhoid; in some of the cases gastric symptoms predominated. The epidemic was found to be due to meat poisoning, although a few of the sick had not eaten any meat. O. Anderson (Hygeia, June, 1913).

When, for any reason, proteins taken into the alimentary canal escape digestion and are absorbed unchanged they undergo parenteric digestion, and in this process a poison is set free. In enteric digestion the poison is most marked in its action at or about the peptone stage. When digestion is normal and proceeds beyond that stage the poison was destroyed by further cleavage. As the intestines of children are more permeable to proteins than those of adults, children suffer more generally from gastrointestinal disturbances, and because of the more rapid absorption from the intestines during the summer time, incompletely digested proteins are taken into the system. V. C. Vaughan (Med. Rec., June 28, 1913).

Many carefully conducted experiments have shown that the house-fly is capable of spreading certain pathogenic organisms. The especial organisms distributed are those producing the various types of bacillary enteritis.

The organisms of this category are also not infrequently found in the intestines of flies under natural conditions, but they do not in all probability remain in the fly for more than 1 or 2 days at the longest. William Nicoll (Brit. Med. Jour., June 30, 1917).

As to the secondary causes, they are as follows: (a) Certain of the infectious diseases, as typhoid fever, advanced tuberculosis,—though the factor of ulceration may enter here or it may be a phase of elimination,—septic processes, dysentery and cholera, and cholera morbus. (b) Portal congestion, whether of cardiac, pulmonary, or hepatic origin, or due to multiple serositis. (c) Extension from contiguous inflammatory processes. (d) Terminal infections in Bright's disease, malignancy, or the profound anemias.

These secondary forms are essentially of the chronic types. As predisposing factors in any case are sudden atmospheric changes, or prolonged heat and drought, or local endemic influences the nature of which are not known. Children are particularly prone to diarrheal disorders (see DIARRHEAL DISEASES OF INFANTS, Vol. IV). Purgative medicines may set up an acute diarrheal condition which, under certain conditions, may continue for days.

MORBID ANATOMY.—The changes are not marked. It is seldom that one observes any injection of the bowels. The mucosa, in fact, is often pale, but in the acute cases it is

swollen, though less than in the chronic form due to portal obstruction. The mucus is increased and often plasters the mucosa in foci more or less extensive. The *tops* of the valvuli conniventes are often injected in the upper part of the small intestine, and the Peyer patches and agminated glands are swollen and often the seat of small superficial ulcers or erosions—follicular enteritis. Sometimes the mucosa exfoliates in patches. In the more chronic forms the chief differences are that the mucus is less if the mucosa has suffered to any considerable extent, and, as stated, the wall of the bowel is often thickened, the result of secondary, proliferative, fibrous change.

A comparatively small part of the intestine may become inflamed, with lymphangitis, lymphadenitis, and secretion into the peritoneal cavity of a free, serous or purulent, sterile or nearly sterile effusion. Hyperemia, swelling and hemorrhages are found in the walls of the intestine. Most cases of the kind are classified as appendicitis or perforating gastric ulcer, and an operation is done at once in this so-called "preperforative stage of peritonitis" or "peritoneal irritation." When possible, the feces, urine, and blood should be examined for bacteria. A low leucocyte count suggests the possibility of typhoid fever. Operation should be exceptionally prompt in cases of streptococcus and pneumococcus enteritis. The main point is to empty the intestines and rest them. If the streptococci are virulent the general symptoms are usually very severe. Lennander (Zeit. f. klin. Med., Bd. lxxiii, Nu. 1-4, 1907).

PROGNOSIS.—The possibility of an acute condition becoming chronic must always be thought of, but, this aside, the acute forms usually terminate favorably in a few days. Any attack is a more or less serious

menace in one already debilitated, especially in children and the aged. In the chronic forms it rarely kills directly, though it may be a factor, especially in septic conditions. In the obstructed portal type the underlying cause will guide one in determining the probable outcome. In both breast and bottle-fed children, especially the latter and even strikingly in overfed children on the breast, a bronchitis or bronchopneumonia may terminate fatally a few days after the development of a diarrheal disorder.

TREATMENT.—In any condition associated with diarrhea the question of food is of paramount importance. In the acute forms it is advisable to **withhold all food for twenty-four to forty-eight hours**, allowing only **pure water** by mouth. A single dose of **castor oil** or a few fractional doses of **calomel** given at short intervals, followed by a **saline**, may be the only medicine required.

For the pain, a few drops of **laudanum**, or if nausea and vomiting be annoying features, a hypodermic of **morphine**, gr. $\frac{1}{4}$ (0.016 Gm.), and **atropine**, gr. $\frac{1}{150}$ (0.0004 Gm.) to an adult, may be required. **Rest in bed** is always advisable, as the attack will be terminated more quickly. **Albumin water, carbonated water, Célestin Vichy**; as to **diet**, rice, arrowroot, cornstarch, or predigested milk are permissible in most cases. Eggs are badly borne by some. Raw or stewed oysters and fish may be given during convalescence and baked potatoes at almost any stage. When the large bowel is involved **enemas** are of special value. Preferably there should be given an initial **saline** followed by **starch water**, 4 to 6 ounces

(120 to 180 c.c.), containing 15 to 20 drops of **laudanum**; this, however, is only to be used in adults. Proctitis in children is often abruptly terminated by wiping out the lower portion of the rectum with **silver nitrate**, 60 grains (4 Gm.) to the ounce (30 c.c.) of distilled water, using a cotton applicator. This procedure is painful, but the result justifies its employment. **Sinapisms** often afford relief, as do **turpentine stupes**. In the chronic forms, in addition to the above, **enemas** should be resorted to daily, **saline** or **starch water** and **castor oil** given every day or two by mouth, and the following also administered internally:—

R *Phenolis* gr. L (3.24 Gm.).
Bismuthi subnitrat. ʒss (15 Gm.).
Tinct. opii camphorata fʒj (30 c.c.).
Syr. zingiberis fʒij (60 c.c.).
Aquæ cinnamomi,
q. s. ad fʒiv (120 c.c.).

M. Sig.: Two fluidrams (8 c.c.) in water every two hours for adults.

There are no intestinal antiseptics in the strict sense, so that one must depend on the occasional sweeping of the entire tract by means of **castor oil**, employing an **enema** after the oil has proven effectual, in the hope that **lavage** may finally remove the offending factor; or **creolin**, fʒj (4 c.c.) to a quart (1000 c.c.) of water, or a 1 or 2 per cent. solution of **quinine and urea hydrochloride** may prove of service. These are best given high and at body temperature, using a fountain syringe and rectal or colonic tube, and having the patient on the back or right side, with the head low and the hips elevated.

In enteritis, especially tuberculous, the author praises highly the action of **methylene blue**. The formula is:

Methylene blue, 0.05 Gm. ($\frac{3}{4}$ grain); sugar of milk, 0.2 Gm. (3 grains). One such pill three or four times daily. After three days the diarrhea will generally cease. The drug used should be pure and free of zinc chloride. M. Perrote (Thèse de Paris, No. 228, 1904).

In certain cases **fluid gelatin** acts very satisfactorily. A 10 per cent. solution in distilled water is boiled for six hours and then filtered, and the resulting fluid keeps clear and fluid for days. A soup made of calves' feet (about 1 pound to 1 quart of water, boiled down to 1 pint) is useful in diarrheal conditions in children and in typhoid fever. Persistence of the diarrhea under the gelatin treatment indicates a tuberculous process. Mann and Herzberg (Therap. der Gegenwart, Bd. xlv, No. 11, 1905).

Cooked starch used to check diarrhea. It is to be sipped from time to time by the teaspoonful, and was found especially useful in the diarrhea of consumptives. Hauffe (Therap. der Gegenwart, Bd. xlv, No. 12, 1906).

High injections of hot Carlsbad water are valuable in chronic intestinal catarrh after failure of ordinary measures. **Gelatin** found in 60 cases of intestinal catarrh to be an ideal article of food in cases in which the muscle-fiber test gives positive results, or when the patient is much debilitated by prolonged intestinal catarrh. Prepared from calves feet and eaten as a meat jelly, flavored with lemon or hydrochloric acid, it is relished for a time by the most fickle appetite. Pure gelatin may be given dissolved in bouillon or in other ways. L. von Aldor (Deut. med. Woch., Jan. 9, 1908).

In acute gastroenteritis, including severe cases of fish poisoning, **kaolin** treatment found highly successful. The kaolin is stirred up with water and drunk while in suspension; 200 Gm. ($6\frac{2}{3}$ ounces) of the clay can be mixed with $\frac{1}{4}$ liter ($\frac{1}{2}$ pint) of water.

One drink usually stopped the diarrhea. Vomiting also ceased at once. In mild acute gastric catarrhs the measure was successful in 27 cases out of 30. In gastrointestinal catarrh of infants the results were good in early cases. Infants were given from 10 Gm. to 25 Gm. ($2\frac{1}{2}$ to $6\frac{1}{4}$ drams), while older children received 50 Gm. (1½ ounces). No addition of milk or sugar can be made. In influenza with diarrhea, kaolin also yielded good results. In some cases injection of 100 Gm. ($3\frac{1}{3}$ ounces) into the rectum stopped the diarrhea rapidly. In intestinal tuberculosis the author was also able to arrest the diarrhea. No constipation, loss of appetite, or meteorism follows. J. Goerner (Münch. med. Woch.; Brit. Med. Jour., April 18, 1908).

Diarrhea is often due to abnormal secretion in the intestine of a fluid which putrefies easily. **Hydrogen dioxide** is the most efficient intestinal disinfectant. Pure **agar-agar** takes up from 10 to 12 per cent. hydrogen dioxide and yields it up slowly, this combination supplying nascent oxygen in the intestine. It was used in diarrhea with serous foul-smelling stools, with good results, but it had no apparent effect upon diarrheas originating in the large intestine or those due to intestinal tuberculosis. A. Schmidt (Med. Klinik, March 28, 1909).

In diarrhea it is often best to order an absolute milk **diet** for a week, and then gradually try the addition of different foods to the diet. Sometimes it is advisable to add **Vichy** or **lime water** to the milk. Peptonization is rarely needed.

The first addition to the milk diet should be toast, eggs, and raw, scraped or chopped beef, or, if such uncooked meat is very disagreeable, the chopped beef may be slightly broiled. **Bismuth**, if used, should not be continued for more than a week without intermission. **Phenyl salicylate** may be given with benefit in doses of 0.3 Gm. (5 grains), three or four times a day, combined with the

bismuth if desired. It should not be continued more than a week.

In some instances **sodium bicarbonate** seems valuable—0.5 Gm. (7½ grains) three times a day. Organic combinations of **tannic acid** are most valuable as astringents. **Quinine** seems often to inhibit looseness of the bowels. The dose should be fair sized, but not enough to cause disagreeable head symptoms. **Ferrous sulphate**, in capsule, in a dose of 0.2 to 0.25 Gm. (3 to 4 grains), three times a day after meals, is frequently indicated. A. D. Blackader (Amer. Jour. Med. Sci., Oct., 1909).

In the treatment of trichocephalus enteritis **thymol** in 1-Gm. (15 grains) doses should be given in a cachet three or four times a day for three or four days, followed by a **saline purge**. No wine, alcohol, or oil should be taken during the treatment. This treatment should be resumed, if necessary, after a few days. Although not always successful in removing the worms, in every case it causes decided amelioration of the symptoms. Cade and Garin (Brit. Med. Jour., March 25, 1911).

Many cases of diarrhea are due to increased irritability of the stomach, the contact of food with the gastric mucosa reflexly exciting intestinal peristalsis. To diminish irritability the following mixture is recommended:—

R *Cocaine hydrochloride*,
Codeine phosphate,
of each gr. xlv (3 Gm.).
Peppermint water.. ℥iii½ (100 c.c.).
M.

The dose for adults is 10 drops, ten minutes before meals. E. Fuld (Semaine méd., Aug. 28, 1912).

Agar medicated with astringents found useful where intestinal mucosa inflamed or ulcerated. **Gambir-agar**, containing solid constituents of 2 c.c. (32 minims) of tr. gambir comp. in 1 Gm. (15 grains) of agar; **tannin-agar**, 0.03 Gm. (½ grain) of tannin to 1 Gm. (15 grains); **simaruba-agar**, 1

c.c. (16 minims) of tincture to 1 Gm. (15 grains); **myrtle-agar**, 1 c.c. (16 minims) of tincture to 1 Gm. (15 grains) recommended, the last especially in diabetic cases. Einhorn (Amer. Jour. Med. Sci., Feb., 1912).

In chronic diarrhea **raw fruits with milk** often brought about better results than a milk diet alone. With a combination of lukewarm milk with **strawberries** pressed through a sieve—1 part of juice to 3 of milk—the author had very good results. Besides the mixture he allowed only crackers and two eggs daily. C. Wegele (Med. Klinik, June 1, 1913).

Study of 640 cases of diarrhea in adults recorded in Bellevue Hospital and the Massachusetts General Hospital. It is a common experience that a patient comes to the hospital with a history of chronic diarrhea of months' or years' standing, and before his case has been thoroughly studied for treatment the diarrhea has ceased and does not reappear, and finally the bowels have to be moved by enemas or laxatives. When the patient resumes his ordinary occupations, however, the diarrhea reappears and its disappearance must be interpreted as due to the remarkable effect of lying in bed. How far this may act by its effect on the splanchnic circulation the authors do not attempt to say. The good effects of purgation in acute and benign cases are familiar, and **castor oil** or **magnesium sulphate** seem secondary only to **rest in bed**. In acute cases **starvation with catharsis** is the ideal treatment. **Warm normal saline solution irrigations** seem to be of value in some obstinate cases and **olive oil** is useful in long-standing cases. **Psychic influences** are also mentioned as successful when other methods fail. Large doses of **bismuth** are sometimes useful. R. C. Cabot and Haven Emerson (Jour. Amer. Med. Assoc., Sept. 27, 1913).

In 256 cases of acute colon bacillus enteritis in soldiers in the trenches, often with 6 to 30 movements a day, and blood in 51 per cent. of cases,

the writer found the best treatment to be daily ingestion of 1 to 2 liters (quarts) of a mixture of 1 part of **condensed milk with 4 of rice water**. The number of stools was thus reduced to 1 a day after 2 to 4 days, and the average stay in the hospital from 26 to 15 days. **Opiates** may be added for sharp colicky pains, and **calomel** and **lactic ferments** for malodorous stools. Lassablière (Bull. de l'Acad. de méd., Mar. 7, 1916).

The writer describes 8 different forms of chronic intestinal disease common in the soldiers returning from the different seats of war. Each requires special treatment. According to the special parasite involved the disturbances subside under **emetine**, **sulphur**, **thymol**, **turpentine**, or **male fern**. In exceptional cases the enteritis may be a sequel of paratyphoid or bacillary dysentery; the rectocolic ulcerations require local measures along with vaccine and serotherapy. Test meals will reveal a functional digestive insufficiency and suggest the treatment. The enteritis may be fermentative or neurotic. Carles (Presse méd., Feb. 10, 1919).

PHLEGMONOUS ENTERITIS.

This is practically a complicating process secondary to strangulated hernia, chronic obstruction, or intussusception. Rarely, from some unknown cause, it may occur as an apparently primary process in the duodenum. It is conceivable, too, that it may occur in septic conditions. It is a purulent infiltration of the intestinal submucosa, diffuse or localized, and the localized form consists essentially of multiple abscesses. Symptomatically, it mimics peritonitis, and except in those conditions in which it is known to occur as a concomitant, viz., strangulated hernia and intussusception, one cannot diagnose it. The only treatment is surgical in those conditions in which the primary factor is known.

Phlegmonous enteritis appears to have a predilection for the upper jejunum and the duodenum, these parts being unable to slide out of the way in case of external trauma or excessive intra-abdominal pressure. Streptococci were isolated from the lesions in all the cases in which bacteriological examinations were made, and also staphylococci in one case. A preceding acute catarrhal enteritis was observed in some cases, and in Moiseev's 4 cases there was a concomitant acute sore throat or gastritis. Treatment should be along the same lines as in phlegmonous gastritis. Cheinisse (Semaine méd., March 10, 1909).

The writer describes a phlegmonous infection involving the latter portion of the ileum, and yet remaining clinically latent. The hypertrophic spleen contained the *Staphylococcus pyogenes aureus* in a pure culture. The writer supposes it to have an enterogenous origin. A. Glaus (Berl. klin. Woch., May 20, 1918).

CROUPOUS OR DIPHTHERIAL ENTERITIS.

DEFINITION.—An intense inflammation of the mucosa of the entire intestinal tract, with more or less necrosis and pseudomembranous formation.

SYMPTOMS.—Briefly, purging, blood-stained mucous stools, tormina, tenesmus, shreds of mucus in the stools, often vomiting and fever and profound prostration characterize the condition. Frequently it is masked by the underlying causal condition. Occasionally there are no characteristic features, and the disturbance may be discovered only at the necropsy.

Frequency and character of the stools occurring in any of the conditions known to be capable of exciting this process are important features of the diagnosis of croupous enteritis.

ETIOLOGY.—The disease is always a secondary process. Occasionally it arises in the course of some of the infectious diseases, as sepsis, typhoid fever, pneumonia, occasionally in leukemia, and as an end-process in malignant diseases, especially those involving the bowel. It may also occur in intestinal hepatic cirrhosis or chronic Bright's disease, and occasionally as a result of mercurial or arsenical poisoning. In the former of these a polypoid colitis and ulcerative lesions are very apt to be associated.

According to the degree of involvement one of several pictures may be presented. In the milder types a dirty, grayish exudate upon a more or less congested base may alone be noted, merely upon the tops of the intestinal folds. This process may be superficial, or the entire mucosa may be necrosed. As a rule, the colon is even more involved than the small bowel. In another form the condition is similar to that of a follicular inflammation, the lymphoid elements being swollen and either suppurating or necrotic, in which case ulcers form; or again, especially in the large bowel, the necrotic pseudomembrane may be more or less continuous, involving especially the cecum or sigmoid and rectum.

PROGNOSIS.—The prognosis is usually grave because of the underlying condition.

TREATMENT.—There is no treatment for the condition directly. Measures should be directed rather to the provocative diseases.

CELIAC DISEASE.

DEFINITION.—Chylous diarrhea or diarrhea alba is a serious form of

intestinal catarrh, met with especially in young children, in which large, loose stools of pale color occur, extremely fetid, pasty, more or less frothy and somewhat like gruel.

SYMPTOMS.—There is a gradual onset, without apparent cause; the characteristic stools are associated with wasting, anemia, and progressive loss of strength. The tympany gives rise to an apparent abdominal fullness, more or less boggy. The course is febrile and the termination usually fatal.

As to the diagnosis, there are to be noted merely the characteristic stools, absence of fever, and serious progressive systemic disturbances occurring in a young child. The etiology of the affection is unknown. No definite morbid tissue change is known to occur. The prognosis is usually fatal.

The treatment consists essentially in the administration of **castor oil**, followed by **enemas**.

SPRUE OR PSEUDO-SCURVY.

DEFINITION.—A tropical, or less often subtropical, disease, occurring especially in those not native of the regions where the disease is encountered, and characterized by a chronic inflammation of the mucosa of more or less of the entire alimentary tract, from mouth to anus, with severe general disturbances and a tendency to relapse.

SYMPTOMS.—The most prominent manifestation is the occurrence of frequent large, loose stools, frothy, pale in color, and usually with an offensive odor, together with more or less abdominal distention, loss of flesh, anemia, and ulceration of the mucosa of the mouth and throat.

Indeed, the name psilosis was given by Thin, from a Greek word meaning bare, with the idea of expressing the fact that rawness of the mucosa is the chief feature. In some cases there are noted minute, herpetic vesicles with an inflamed areola, rupture of which results in small, very tender erosions or ulcers, and still larger, denuded patches, with more or less mucopurulent material covering them. These lesions occur on the mucosa of the mouth in contact with the teeth. The papillæ of the tongue are swollen, and the lips and tongue cracked. Between the attacks or after recovery, more or less atrophy of the tongue occurs, with some stiffening of the organ. A glazed appearance of the tongue due to permanent destruction of the mucosa, gastric and intestinal disturbances, gaseous distention, an earthy-colored skin,—often due to pigmentation,—and marked irritability and mental disturbances characterize the condition. One remarkable feature is the latency of this affection, even after removal of the patient from the tropics. In some instances the disease makes its appearance or recurs in non-tropical regions many months after apparent recovery.

As sprue progresses, an anemia of typical secondary type develops. A marked leucopenia may ultimately result. There are microcytes and megalocytes, together with poikilocytosis. Polychromatophilia and basophilic degeneration are also not uncommon. In severe cases, especially toward the termination of the disease, the blood-picture may resemble very closely that of progressive pernicious anemia. The blood examination is useful for determining the progress of a case of sprue and its ultimate prognosis. Nothing resembling para-

sites was ever seen in the blood of the author's cases. Low (Jour. Trop. Med. and Hyg., May 1, 1912).

DIAGNOSIS.—The condition of the mouth and tongue, the tendency to remissions and relapses, the character of the stools, and the fact that the disease is usually tropical in its distribution are features of assistance in the diagnosis.

ETIOLOGY.—Chief among these is residence in the tropics, usually over a long period of time. Exhausting disease or pregnancy, prolonged lactation and lues invite the occurrence of the disease. As to the direct exciting cause nothing is known. Musgrave states that amebæ coli are often present, but it is well known that these organisms are often present in the stools of individuals residing in the tropics. Most common in Java and Cochin China, the disease constitutes some of the chronic diarrheas of the West Indies, Africa, India, Ceylon, the Philippines, and tropical America.

MORBID ANATOMY.—Sprue is a progressive catarrhal inflammation of the mouth and alimentary tract, leading to atrophy and secondary fibrous tissue formation, which, *e.g.*, in certain cases of pernicious anemia, are doubtless in a measure responsible for the grave changes in nutrition, progressive loss of weight, and anemia. The tissues are everywhere dry, so that bodies mummify rather than decompose. In the intestine, moreover, are to be found hyperemia, erosions, ulcerations, pigmentations, and cicatrices. Ulcers are especially frequent in the colon. The lymphatic apparatus of the bowel and the mesenteric glands are enlarged, and the former are prone to ulcerate.

There is a great increase in the number of cases in North and South Carolina, and in Georgia. In the diarrhea of sprue the feces are extremely acid in reaction, yeasty and passed during the early morning hours. They show tremendous loss of fat, as much as 59 per cent. Wood (N. Y. Med. Jour., June 1, 1918).

PROGNOSIS.—The condition is always a serious one, with a possibility of relapse; yet according to Manson, a goodly proportion of patients recover under treatment.

TREATMENT.—To be effectual, this must be applied early, as in well-established cases or cases that have existed for any length of time recovery is impossible. In every instance food should be as bland and unirritating as possible; for this reason, as Manson states, milk treatment—especially **predigested milk**—affords the best results. The character of the bowel movements should be frequently noted as a guide to the continuance of a strict **milk diet**. The milk should be taken warm, and preferably sipped. An occasional dose of **castor oil**, followed by an **enema**, should be administered. **Rest in bed** during the active stages of the disease, with concomitant use of a **broad abdominal binder**, is indicated. Upon improvement in the stools the amount of milk may be gradually increased. Manson further recommends the use of strawberries, speaking of them as being valuable in any stage of the disease. Gradually an egg and well-boiled arrowroot-starch may be added to the **diet**. Drugs are of secondary importance, except the castor oil. Alcohol is, as a rule, harmful.

In the acute gastric variety of sprue, oral, substernal, and gastric

pains predominate, and the changes in the mouth occur early, and are very pronounced. Obstinate constipation rather than diarrhea is the rule. Emaciation is rare, even though the anemia be great, the latter serving to differentiate the condition from acute gastric catarrh. In this form **calomel** in full doses is indicated, even where diarrhea is present. For the first twenty-four hours, or longer if possible, warm water with a little **sodium bicarbonate** is advised, then **milk**, diluted with an equal part of **lime-water**. This method should be continued for a week. As long as no solid foods are being taken, no anesthetic paint for the tongue need be applied, but the mouth should be frequently rinsed with a 1 per cent. solution of **phenol**. After the regeneration of the epithelium **predigested foods** are of service, but **malted preparations** are to be **interdicted**. Later on, farinaceous foods and fruits are allowed. Cachets of **rhubarb** (10 grains—0.6 Gm.) and **chinosol** (5 grains—0.3 Gm.) should be administered every morning fasting. The condition of the tongue as regards pain is the index of dietary extension. In all types of sprue **fats are barred**. In the chronic enteric type, in which diarrhea is pronounced, **rest**, **body warmth**, and an **exclusive milk dietary** are the requisites. After an initial **purgative**, these are to be strictly enforced until the diarrhea is ameliorated. Internally, the author prescribes **chinosol** tablets of 5 grains (0.3 Gm.) each, administered, at first, thrice daily, and then reduced as progress is made. The amount of milk assumed to be necessary is placed at 100 ounces (3000 c.c.), but care must be taken to limit the amount ingested to the stomach capacity, and milk somatose may be substituted in part. Where the stools remain white, **pancreatizing the milk** may be resorted to. **Lavage of the bowels** with a weak solution of **chinosol** at blood-warmth may expedite recovery. To reduce hyperperistalsis, **codeine** in 1-grain (0.065

Gm.) doses may be administered. In fairly excoriated and possibly prolapsed rectal conditions, a **morphine and tannic acid suppository** is indicated. After five weeks on milk, bananas, apples, watermelons, papaya, and cucumber may be added; then fresh fish with vegetables and bread, and, lastly, chicken or lean meat. D. J. Galloway (*Jour. of Tropical Med.*, Oct. 16, 1905).

Case of man aged 29 years suffering from sprue. On a **strict milk diet** he gradually improved. But he was unwilling to limit himself to milk, and any increase of the diet brought on a relapse. Finally, 1 pound of **strawberries** were ordered daily; within one week improvement was noticeable. Complete recovery took place in two months, and was maintained. Squire (*Lancet*, Dec. 15, 1907).

In a severe case from India, the **strawberry diet**, 4 pounds being eaten a day, caused great improvement. McPhedran (*Trans. Assoc. Amer. Phys.*; *N. Y. Med. Jour.*, June 1, 1918).

HILL DIARRHEA.

DEFINITION.—A diarrheal disorder met with in elevated places, in tropical and subtropical countries, and occurring especially in persons recently removed from lower levels. Frequent frothy, liquid, or pasty stools, with anorexia and lassitude, and a tendency to relapse, are the chief features. The condition is of special importance in the tropics, as it often invites more serious conditions, such as sprue or dysentery.

SYMPTOMS.—Flatulent dyspepsia; loss of appetite; malaise; light-colored, more or less frequent stools, followed by a white flux or so-called "diarrhea alba," with or without pain, and a gradual development of loss of flesh and anemia are the important features. The prognosis is good. History and environment are the important diagnostic features.

ETIOLOGY.—Apart from the fact that removal to higher levels invites the disease in the tropics, no definite cause is known to exist.

PATHOLOGY.—It is probable that a variety of tropical disorders characterized by diarrhea occur, all bearing some mutual relationship. The lesion in hill diarrhea is believed to be catarrhal and not atrophic, as is the case in sprue.

TREATMENT.—Rest and a bland, **absolute milk diet** are necessary. In some instances the **milk** should preferably be **predigested**. If the disease continues, removal from the locality is imperative.

CHOLERA MORBUS.

SYNONYMS.—Cholera nostras, sporadic cholera.

DEFINITION.—A diarrheal disease occurring in the summer months, characterized by repeated vomiting, purging colicky pains, rapid and profound weakness, and muscular cramps.

SYMPTOMS.—The condition is often rather abrupt in onset. It occurs only in the heat of summer and especially in the temperate zones, and is initiated with vomiting, diarrhea, and colicky abdominal pain. After the stomach is emptied of the food, bile and mucus continue to be evacuated for some time, after which there is non-productive retching. The stools, at first fecal, soon become watery and even resemble the rice-water stools of true cholera. The temperature varies within wide limits; even hyperpyrexia may occur. Thermometric readings should always be rectal. The features become pinched, the skin cool, and the pulse small and rapid; muscular cramps set in, espe-

cially in the legs; thirst is intense, and water often serves to excite further effort at vomiting. The urine diminishes in amount and becomes high colored and albuminous.

DIAGNOSIS.—The absence of an outbreak of true cholera alone serves to differentiate a well-marked case of cholera morbus from the Asiatic form. The history is important in order that one may exclude irritant poisons, arsenic, or ptomaine poisoning. A bacteriological examination is usually unnecessary in an individual case, but may be imperative if for any reason a suspicion of true cholera arises.

ETIOLOGY.—Among the predisposing factors, season is the most important, as in cholera infantum. It is probable that some of the various forms of the dysentery bacillus may be responsible, though spirilla have also been accused, notably that of Finkler and Prior. Excessive amounts of food, tainted food, and the use of unripe fruits may all play their part during the warm months.

Out of 114 persons in an institution, 37 showed more or less serious symptoms after a meal of haddock killed four and a half days previously. The fish was apparently fresh and firm and had been boiled as usual for eight minutes after having been cut in small pieces. Fish should not be held back by dealers or housekeepers until Friday, but should be delivered as soon as possible after the fish are dead, and be cooked at once. Roepke (Archiv f. Verdauungs-Krank., Bd. xiii, Nu. 4, 1907).

PATHOLOGY.—As is well known, in the so-called "eliminative diarrheas" occurring in septic conditions there may be no gross change present. In other cases merely hyperemia

and more or less catarrhal swelling of the mucosa are found.

PROGNOSIS.—This is usually good, except in young children, old people, or those already debilitated through disease.

TREATMENT.—**Absolute rest in bed** is necessary. **All food should be withheld** for forty-eight hours, **only pure water being allowed**. **Cataplasms or turpentine stupes to the abdomen**, and often the use of a **firm binder**, afford some comfort. **Carbonated waters** or frequent sips of **Célestin Vichy** given **ice-cold** serve best to allay the thirst. For the relief of the more urgent symptoms one must have recourse to hypodermic injection of **morphine**, from $\frac{1}{8}$ to $\frac{1}{2}$ grain (0.008 to 0.03 Gm.), according to the severity of the condition. This should not, of course, be used in the case of children.

In the beginning a dose of **castor oil** should be administered, and cereals, broths, predigested milk, or egg and milk should constitute the only **dietary** for several days.

In an urgent case of cholera nostras in a woman 39 years old the author prescribed as follows: **Veratrine**, 5 mg. ($\frac{1}{12}$ grain), to be dissolved in 25 c.c. ($4\frac{1}{2}$ drams) of diluted alcohol, and then diluted with 200 c.c. ($6\frac{1}{2}$ ounces) of distilled water. Dose: One tablespoonful the first four times at half-hour intervals; after that every two hours. At the end of one hour the diarrhea and vomiting were arrested. Next morning the temperature was normal and the pulse good. Satisfactory results were also obtained in a number of other cases. G. Maetzke (Zeit. f. aerzt. Fortbildung, S. 713, 1909).

CHOLERA ASIATICA.

DEFINITION.—A specific, infectious or communicable disease, due

to the comma bacillus of Koch, and characterized by violent purging, repeated vomiting, cramps, suppression of urine, and collapse, a more or less marked febrile reaction, and a high mortality.

HISTORICAL NOTE.—Hippocrates and later Galen refer to cholera, but their allusions indicate nothing more than a serious form of diarrhea. The disease has probably been endemic in India for centuries, but the first definite record dates from the early part of the nineteenth century. It is constantly endemic in India, varying in extent and severity, but, curiously, is not known to have spread beyond the confines of Asia till the nineteenth century. It is most ripe in the region of the Delta of the Ganges. It spreads along lines of commerce and travel, and outbreaks elsewhere have been preceded by unusually severe outbreaks in India. Its propagation has been effected by land rather than sea routes, and many epidemics have spread by way of Russia. It first invaded Europe in 1826, the epidemic covering a period of thirteen years. During this time it made its first appearance in Great Britain and America, being carried from Great Britain to Quebec in immigrant ships in 1832. It spread along the Great Lakes as far as the Mississippi and into the United States by way of New York. In the following year it appeared in France, Spain, and Portugal, and in 1834 in Italy and northern Africa. The next outbreak occurred in Europe in 1840, and lasted eleven years, though recurrences occurred in the United States in 1835 and 1836. In 1848 it entered New Orleans from Havre, and spread up the Mississippi and west to California, recurring in 1849. During a third European invasion lasting nine years from 1848,—hence overlapping the previous outbreak,—it was again introduced into the United States by immigrant ships entering New York. In 1866 and 1867 the disease once more visited the United States, though its manifestations were less serious. This was the terminal portion of the fourth European epidemic which lasted from 1863 to 1867. The fifth existed from 1867 to 1873, and again at the end, in 1873, a mild

outbreak occurred in the United States, coming via New Orleans from Jamaica. During the sixth European invasion, 1879 to 1887, Koch, in Egypt in 1883, discovered the specific cause of the disease. The last extensive epidemic to ravage Europe lasted from 1891 to 1895, and, while occasional cases have been brought by ships both to Great Britain and America, no spread of the disease has occurred in either country since 1873, though in 1893 a number of cases occurred in seaport towns of Great Britain. In all of these wanderings of the disease the original source could be traced to India in each instance.

SYMPTOMS.—Owing to variations in virulence of the infecting organism and to varying degrees of susceptibility of the host, the clinical picture is more or less inconstant. The period of incubation is not definitely known. Probably never more than ten days, and usually from three to five days, elapse between the receipt of the infecting organism and the appearance of symptoms. Fairly definite stages mark the course of the disease, viz., a premonitory diarrhea, passing into an evacuating phase, then a period of collapse followed by a reactive condition.

In many instances the attack sets in abruptly, with very severe symptoms,—almost constant vomiting, purging, and muscular cramps,—but in others a distinct prodromal diarrheal stage manifests itself, either abruptly or preceded by abdominal, colicky pain, nausea, and vomiting, diarrhea and a sense of depression thereupon supervening. The period of evacuation may be the initial evidence of the disease, as already stated, but whether preceded by colic and diarrhea or not, the frequency of the diarrhea and the profuse liquid stools rapidly exhaust the patient. Tor-

mina and tenesmus are the rule. Within twelve to twenty-four hours, often less, vomiting sets in, and soon both diarrhea and vomiting become constant. There is rapid loss of flesh, cramps of great intensity and localized, even in the abdomen and back, as well as in the muscles of the legs. The features become drawn and pinched, the skin more or less cyanotic or ashen in color, and the eyes deep-set. Thirst is extreme, the tongue is white, and the body surface cold, often moist and clammy. The pulse becomes weaker, more rapid, and finally imperceptible, and the heart sounds are very feeble. The temperature is often low in the mouth and axilla, but the rectal temperature may be 102° to 105° F. At first restless, the patient is rapidly enfeebled and becomes apathetic, though consciousness remains unimpaired. The stools of these cases are at first fecal, rapidly becoming thin and watery and grayish white, containing little bodies resembling rice grains; hence the term "rice-water stools" and "vomit," since these bodies are found also in the vomited material. There are mucin clumps entangling bacteria (agglutinations), epithelial cells, granular material, and occasionally a little blood. Owing to the profuse diarrhea and consequent loss of blood-serum, the specific gravity of the blood is higher than normal.

The stage of collapse sets in very early in those cases with incessant diarrhea and vomiting. Then dyspnea occurs, the skin becomes dry and wrinkled, the voice husky, the urine diminished or suppressed, and coma may supervene and terminate the scene. It is in this stage that the greatest mortality occurs.

After a few hours, up to twenty-four, or even a little longer in less urgent cases, the stage of reaction sets in: diarrhea lessens, the stomach becomes more tolerant, the circulation becomes stronger, the skin warmer, the color improves, urine is again excreted, and strength returns.

About 3 per cent. of 326 patients went into a condition resembling typhoid with tympanites and temperature above 101° F. (38.3° C.) for more than a week. Some of these gave the Widal reaction in the stronger dilutions, but they all recovered within a fortnight. H. Stevens (Brit. Med. Jour., March 25, 1911).

In the uremia of cholera the writer found that the retention of nitrogen in the 34 cases tabulated amounted to from 3.31 to 5.9 Gm. urea per liter of the blood serum in 50 per cent. of the patients. In 10 others it ranged from 1.75 to 2.72 and in only 7 was below this. In another group of 4 cases Ambard's constant was calculated from the urine and blood. The retention of nitrogen in 50 per cent. was thus higher than the figures obtained even with contracted kidney. There must have been formation of urea from the albumin of the body. All these high nitrogen patients died. Valk and de Langen (Nederl. Tijdsch. v. Geneesk., Apr. 14, 1917).

During an epidemic a variety of types is presented. Cholera organisms have been recovered from the stools of apparently normal, symptom-free individuals, while others may be ambulatory, but complain of malaise and loose bowels, with loss of appetite. When the phenomena are a little more severe, with but slight evidence of collapse and a prompt reaction, they are spoken of as *choleraic diarrhea* or *cholerine*. In the most intense types death may occur within a few hours, without vomiting or purging,—the so-called

cholera sicca. These cases, however, are rare. Death may occur, too, from embolism or thrombosis causing sudden respiratory, or either prompt or more gradual circulatory, failure. Early coma may terminate in death before the development of the usual train of symptoms; or, after reaction has set in, a relapse may occur with the rapid development of serious or fatal effects. Hyperpyretic cases (rectal temperature) are uncommon and often fatal. A prolonged stage of reaction may occur during which a typhoid state predominates, with dry mouth, lips, and tongue, sordes, delirium, subsultus, bedsores, and, when the issue is not fatal, prolonged convalescence.

The cholera vibrio remaining alive in the gall-bladder of treated cholera patients seems capable in some instances of developing its toxin, which passes freely into the circulation, and which causes late death. Late uremia may also be explained upon a similar basis. Greig (Lancet, Nov. 23, 1912).

Eruptions may occur, usually urticarial or erythematous, and rarely bullous. When urinary suppression is pronounced, the case is apt to assume a *uremic type*.

Of 102 cases of cholera treated with **hypertonic saline injections** in 1909, only 14 per cent. died in the collapse stage. Fatal collapse can still occur in very severe cases some hours after as much as 4 pints (2000 c.c.) of fluid have been injected into the veins. Nine per cent. of the total cases died in the "stage of reaction," the main feature of which is usually a marked rise of temperature, which either continues high, a typhoid-like state ensuing, or in very severe cases shows a subsequent considerable lowering, with early fatal result. The **cold bath** appears to be the only measure likely to control the temperature, but heart-

failure may ensue, and this of itself is an occasional cause of death in feeble subjects during reaction without any marked rise in temperature. An increase in the respiratory rate is commonly a sign of a severe reaction and an indication for **ammonium carbonate** and **sal volatile**, while if cyanosis ensues **oxygen inhalations** appear to be indicated. **Alcohol should be avoided**, as it tends to increase vasomotor paralysis.

During 1909 lung complications were unusually frequent in Calcutta, 5 per cent. of the deaths being due to them. **Ammoniacal preparations** were here also of most use. The mortality in the uremic stage was 6.9 per cent.

Suppression of urine after cholera is really due to failure of restoration of the circulation through the kidneys, which have become intensely congested and full of hemorrhages during the collapse stage. The obvious indication is to endeavor to force the blood-pressure up to well over 100 mm., steps being taken as soon as reaction occurs, two or three days being then available, as a rule, before very urgent symptoms will ensue. Every patient whose blood-pressure remained for several days below 100 mm. died with uremic symptoms.

The measures used to raise the blood-pressure when deficient in the later stages were the following: (1) Half to 1 pint of **normal saline solution** per rectum every two to four hours, 5 minims (0.3 c.c.) of a 1:1000 solution of **adrenalin chloride** being added to each; (2) **dry cupping over the kidneys** morning and evening; (3) **digitalin** subcutaneously twice a day, and if this fails **strophanthin**, up to $\frac{1}{100}$ grain (0.00065 Gm.), administered intravenously (apparently successful in 2 cases).

Opium or morphine after collapse has once set in predisposes to uremia later. Leonard Rogers (Therap. Gaz., Nov. 15, 1909).

As to the blood changes, leucocytosis prevails throughout the disease.

but is apt to become rather higher before death, and in the algid types. The increase is especially polymorphonuclear, as would be expected. Owing to the excessive blood-concentration from the loss of water, the result of almost constant vomiting and purging, polycythemia is the rule, with a corresponding increase in hemoglobin.

Complications and Sequelæ.—Membranous colitis, tracheobronchitis, laryngitis, or urethritis may occur, as may likewise suppurative parotitis.

Among the less urgent sequelæ are anemia, debility, insomnia, nervousness, marked depression, melancholia, and chronic diarrhea. Abortion is the rule in pregnant women. More serious are pleurisy, pneumonia, and pulmonary edema. Arthritis is not rare. Conjunctivitis is frequent, and occasionally corneal ulceration occurs. Rarely gangrene of the extremities, nose, ears, penis, or scrotum makes its appearance.

Painful muscular cramps may persist for some time after recovery, as may also gastrointestinal disturbances.

DIAGNOSIS.—Clinically, the most severe forms of cholera nostras closely resemble Asiatic cholera, but doubt would only exist in some seaport in the event of arrival of a vessel from a locality known to be infected. A bacteriological examination alone would serve to distinguish the two conditions. In view of the well-known epidemic character of Asiatic cholera, it is not likely that errors in diagnosis would often arise.

Ptomaine and mushroom poisoning, or arsenic or sublimate poisoning, may resemble cholera symptom-

atically, but it is scarcely conceivable that errors in diagnosis would occur except in localities where cholera prevails or happened to exist at the time. A study of the intestinal flora would then be indicated.

The resemblance of the algid type of malaria to cholera should always be borne in mind, as its early recognition by finding the parasites in the blood is essential to its successful treatment with quinine. Ptomaine poisoning may cause difficulty, but in several cases the author has found the absence of the typical leucocytosis of cholera of great differential value. Leonard Rogers (*The Antiseptic*, Feb.-Mar., 1909).

In bacteriological examination of alvine discharges or the material taken from the rectum by swabs at the New York Quarantine Laboratory, it was found that nearly half of the cases, even where there was no clinical evidence or special reason to suspect cholera, showed curved bacilli of various sizes and shapes, in many instances resembling the cholera vibrios. Where these forms are numerous, the case should be regarded as suspicious until the cultural characters prove it to be otherwise. The presence of a few actively motile organisms in the hanging drop adds considerably to the suspicion. In cholera carriers and mild cases of this disease the cultures may show the vibrios even though the smear shows very few suspicious organisms. It is usually only in the active cases that the smear and hanging drop, made directly from the discharges or rectal swab, will afford such unmistakable evidence as is required to pronounce the case true cholera from the point of view of the bacteriologist. In all other cases it is necessary to isolate pure cultures and prove them cholera vibrios or otherwise by suitable bacteriological tests. Doty (*Amer. Jour. Med. Sci.*, Jan., 1911).

The writer applies the complement-fixation test to cholera, using fresh

stool heated to 60° C. for twenty minutes; 1 c.c. is sufficient for the test. For the antibody he uses an agglutinating cholera-immune serum; for the alexin, fresh guinea-pig serum diluted 20 times with physiological solution; the hemolysins are from the serum of rabbits prepared with beef red corpuscles and the red corpuscles used in the test are likewise from beef; they are suspended in 20 parts of physiological solution. The results obtained in 11 cases to date all confirmed the accuracy and reliability of the test, while the findings were constantly negative in patients with other affections. Connio (*Gaz. degli Osped. e delle Clin.*, Dec. 21, 1911).

The rule may be adopted to consider as truly choleraic every choleraiform vibrio in which one or the other of the two following characteristics is recognized: (1) Agglutination, in the proportion of 1:1000 at least, by a cholera serum the activity of which is 1:4000 or more. (2) Positive Pfeiffer reaction.

The proof of the existence of the cholera vibrio in persons presenting no clinical signs of anatomicopathological lesions does not necessitate a declaration of the existence of cholera. The following general indications may be recommended as permitting in the great majority of cases a positive diagnosis within twenty-four to thirty-six hours: (1) When mucous flakes are available for examination, a microscopic investigation of the same, in stained preparations and in the hanging drop. (2) The isolation of the vibrios, employing for the purpose agar media, at a temperature of 37° C. (a) Plant plates of ordinary suitably alkalinized agar and of Dieudonné's medium, using for the latter a riziform particle, or an equivalent quantity of feces. (b) Plant in 50 c.c. of peptone solution 1 c.c. of fecal matter. After a stay of six hours in the incubator (or twelve to eighteen hours if need be) at 37° C. take several loopfuls from the surface and plant with them several plates of Dieudonné medium and ordinary agar.

(c) Investigate the agglutination reaction, using drops for the purpose from the isolated colonies, the properties belonging to cholera vibrios, and secure pure cultures. (3) Demonstrate the character of the vibrios obtained in pure culture by the reaction of agglutination or that of Pfeiffer.

The conditions are much more favorable to the discovery of vibrios if pathological materials (feces or intestinal contents) are collected as early in the attack as possible, or secured from the cadaver as early as possible after death. Examinations made of the small quantity of material collected by a sound introduced into the rectum, in the living body, or from the cadaver are unreliable. It is sometimes possible to recognize that a person even in good health has undergone an attack of cholera by determining whether his blood-serum gives with a genuine cholera vibrio the immunity reactions, viz., agglutination or the reaction of Pfeiffer.

The medium of Dieudonné is prepared as follows: Equal parts of a normal solution of potassa and defibrinated ox blood are mixed and sterilized in the autoclave (sol. A.); there is also prepared according to the ordinary technique a nutrient agar, exactly neutral to litmus (sol. B.). Seven parts of B are mixed with 3 parts of A and poured upon plates. H. D. Geddings (*Public Health and Marine-Hosp. Service of U. S.*, Report No. 75, 1912).

ETIOLOGY.—The pathogenicity of the organism isolated by Koch in 1883 and claimed by him to be the sole cause of cholera has been abundantly confirmed. The distance is not contagious in the strict interpretation of that term, and it is generally conceded that the organism must be swallowed in order to produce infection. Hence, contaminated food and drink, whether the contamination has occurred through the medium of flies or in any other way, as by washing

utensils or food with infected water, are necessary for the development and spread of cholera. Drinking-water is by far the commonest source of infection, as was the case in the Hamburg epidemic of 1892. Not much is known as to the factors concerned in individual susceptibility, but, in the presence of infected material, gastrointestinal troubles increase the likelihood of infection, and newcomers into an infected area, as is the case with typhoid fever, are more susceptible than natives. Sanitation, personal hygiene, and pure food and drink are the all-important factors in preventing infection, and this presupposes isolation of every suspect (for quarantine is useless) and the destruction of all stools, urine, and vomited material, or articles which have become contaminated.

The comma bacillus, by which name the organism is most generally known, is comma-shaped, or may be even more twisted, having 1 or 2 corkscrew-like curves. Found chiefly in the intestines and recoverable from the stools of infected individuals and in cases of somewhat protracted course, the organism penetrates the mucosa. *Post mortem* it has been found in some of the adjacent lymph-glands, but it has not been recovered from the blood or viscera.

The organism is variable in size, shape, and degree of mobility, and in the involution stage becomes so changed as to lose all semblance to its rapidly growing forms. It grows well upon many media and slowly liquefies gelatin. Animal experiments lack uniformity in their results. Laboratory animals show practically no susceptibility when the germs are

administered by mouth under ordinary conditions; but after neutralization of the gastric contents and control of the peristalsis with opium, a profuse watery diarrhea may result, the stools containing the organism in vast numbers. Animals can be immunized against cholera vibrios, and the immune serum then acquires bacteriolytic properties. This was first discovered by Pfeiffer and has since become known as "Pfeiffer's phenomenon." The organism also agglutinates when to a suspension of it there is added the serum obtained from a cholera patient or an immune animal. Comma bacilli are killed by exposure to a temperature of 50° C. for an hour. They survive for a day or two at most in distilled water, but may live for months in ordinary river waters. As they are rapidly destroyed by drying, it is only upon moist substances or in water that they can retain their vitality for any length of time.

One must take care in all epidemics of cholera not only to disinfect the stools and other excreta of the patient, but to see that all feces of healthy persons are disinfected, for a slight fecal admixture is all that is needed to cause a flourishing growth of the vibrio in any soil or water. M. Pergola (Il Policlinico; Med. Record, Dec. 30, 1911).

The soil in the coolie quarters at Batavia become hotbeds of cholera whenever the disease is epidemic. The normal flora in the soil and other factors soon destroy the cholera germs on the soil, so that none survive longer than 2 days when the ground is damp; during dry weather, up to 4 or 6 days. Flu (Meded. van den Burg. Geneesk., No. 3, 1917).

It is generally conceded that no specific soluble extrabacterial poison is produced by the comma bacillus.

In the rabbit the strongly acid gastric juice destroys the micro-organisms readily. Apparently the route of the vibrio from mouth to intestine is through the general circulation. The point of election is in the vicinity of the ileocecal valve. Sanarelli (*Presse méd.*, Nov. 16, 1916).

Immunity may be produced in the usual way in laboratory animals, *i.e.*, by first employing injections of dead organisms and gradually administering minimal amounts of attenuated living organisms. Finally the animal will survive injections of large amounts of untreated living bacteria. A serum thus produced has the power to protect against many times the lethal dose of the living vibrio.

PATHOLOGY.—One of the most striking post-mortem evidences is the rapidity with which rigor mortis sets in. It is not at all unusual for muscular contractions to occur in the limbs and in the facial and ocular muscles, so that with the post-mortem elevation of temperature, which is not unusual, these grotesque phenomena are often rather uncanny. There are no changes of an absolutely definite type, though the marked emaciation with dryness of the skin; the dark, thick blood; the swollen and sometimes hyperemic mucosa, with a low-grade peritonitis, the stickiness probably being due to the abstraction of water; the characteristic bowel contents, the small spleen, and the cloudy swelling of the liver and kidneys, the latter being especially involved and showing advanced epithelial degeneration, are decidedly suggestive changes. The bladder is generally empty. The right side of the heart and the venous system are apt to be found engorged, while the left heart and the arteries

are practically empty. All the tissues are relatively dry, owing to the tremendous loss in their watery content. Bacteriological study reveals, of course, the true nature of the disease.

The cholera vibrio is present in large numbers in the bile, often in pure culture. In some cases the bacillus is retained in the bile much longer than in the intestine after apparent recovery. In about 10 per cent. of cases there is an acute cholecystitis due to the presence of the cholera bacillus in the gall-bladder. Usually the process is an acute hemorrhagic, rather than suppurative, condition. In the remaining cases there is only a catarrhal cholecystitis, with thickening of the bile and an increase of mucus. The bile makes an excellent emergency medium for cholera cultures. The bone-marrow undergoes an acute hyperplasia in cholera. In addition it shows inflammatory changes. At times a real osteomyelitis may develop in the course of the disease. Kouleshi (*Roussky Vrach*, Oct. 31, 1909).

The stage of reaction and uremia in cholera and the acid intoxication of diabetes have the following features in common: (1) There is a well-marked tolerance for alkalies. (2) The relative and absolute amounts of ammonia in the urine are considerably increased in both diseases. (3) In both diseases a diminished alkalinity of the blood has been reported. (4) Injection of alkalies in the late stages of either disease usually modifies the course without affecting the ultimate termination. Acetone and diacetic acid have been noted in the urine of cholera cases, but no excess of acid has been found which corresponds to the quantities of *b*-oxybutyric occurring in diabetes.

Loss of alkali from the body apparently may result from a pronounced diarrhea, this loss giving rise to a relative acidosis. It also is conceivable that there may be an excessive quantity of acid present, resulting

in the production of an absolute acid intoxication in cholera. Sellards and Shaklee (Philippine Jour. of Sci., Feb., 1911).

Although the urine contains no nitrous acid in healthy persons, that of fresh cholera cases contains large quantities, more than sufficient to poison. When nitrous acid appears in the stomach and intestines it excites cholera-like symptoms. Emmerich (Münch. med. Woch., May 2, 1911).

The resemblance in certain points between cholera and Addison's disease is so marked that it suggests that cholera may be merely an acute specific enteritis with toxic nervous symptoms, especially of the innervation of the cardiovascular apparatus, due to deficient adrenal functioning. The results obtained with **epinephrin** in 9 cases justified further trials of it in the treatment of cholera, even in large doses. Piovesana (Gaz. degli Osped., May 26, 1912).

On sugar free nutrient agar to which the writers added 1 per cent. saccharose, 0.25 per cent. nutrose and 0.0625 per cent. bluish eosin, the cholera colonies have red centers, while the colonies of *B. coli* are uniformly pink. Teague and Travis (Jour. of Infect. Dis., June, 1916).

While, during the year 1916, 1340 cases of cholera and 513 cholera deaths occurred in Manila, there were also detected, among 243,974 persons examined, 1643 cholera carriers, or 0.67 per cent. of the whole number. In intestinal contents and bile of 212 cases of cholera, the authors found the vibrio in the bile in 65.2 per cent. of cases and in the bile alone in 5.7 per cent. Among 32 cholera carriers detected after death, the vibrio was found in the bile in 75 per cent. of cases and in the bile alone in 43.7 per cent. Thus, in cholera cases, the organism is occasionally recoverable from the bile where absent from the feces, and routine examination of both bile and feces is important. Crowell and Johnston (Philippine Jour. of Sci., Mar., 1917).

PROGNOSIS.—This necessarily varies with the extent of the outbreak and the type of epidemic, some epidemics being more severe than others. The mortality is usually large, and in the severer outbreaks 50 per cent. and even more of those manifesting symptoms succumb. The disease is especially dangerous in the extremes of life, though nursing children are very rarely infected. Women are infected less frequently than men, but the disease is more apt to prove fatal in pregnant women. Chronic renal disease, cardiovascular disease, malaise, and depraved nutrition all exert an unfavorable influence on the prognosis.

PROPHYLAXIS.—The most important factor is the isolation of infected individuals and the complete destruction of all vomitus, dejecta, urine, and infected clothing. All milk and water used should previously have been boiled, and all food and drink should be carefully guarded against possible infection by flies and dust, as well as from contamination of utensils through the use of polluted water for washing purposes. In the presence of an epidemic, digestive disturbances should be cautiously guarded against, as they increase susceptibility. Through protective inoculation, first practised by Haffkine in India, and later by Strong in the Philippines by a process devised by himself, fairly good results have been obtained, but these results are not comparable with those accruing from efficient sanitation, personal hygiene, and the absolute isolation of infected individuals, with destruction of all infected material.

In the **prophylaxis** of cholera all water used for drinking or cooking

purposes should be **boiled**; likewise all milk. The germ is readily killed by acids and infection may be prevented by the use of dilute mineral acids internally, *e.g.*, dilute **sulphuric acid**, a few drops thrice daily. Even carbonic acid gas in **aërated waters** (not soda water) will kill the germ, provided there have elapsed at least three hours between the bottling of the gas and its use. Five to 10 drops of dilute sulphuric acid to a bottle of lemonade is most useful. **Floors** of houses may be **washed with potassium permanganate**, $\frac{1}{2}$ ounce (15 Gm.) to a pail of water. **Wells** should be **disinfected** to the extent of 1 ounce (30 Gm.) of **permanganate** to every 3 feet of water. If after half an hour there is a red color in the water in the well, enough permanganate has been put in; if not, more should be added. There should remain a slight red color in the water at the end of twenty-four hours. It is best to add the permanganate at night, so that by next morning the water will be usable and its color not so objectionable. A. G. Newell (Indian Public Health, Sept., 1908).

A patient with cholera or suspected of having cholera **should be isolated** immediately. The room or ward should be rendered fly-proof by **screening**. In the room there should be a large vessel containing 5 per cent. solution of **carbolic acid** crystals for the immediate reception of soiled linen. The stools and vomit should be **disinfected** at once by adding an equal volume of 5 per cent. **carbolic acid** solution, 5 per cent. **formaldehyde solution**, or milk of lime. The mixture should be covered and allowed to stand for two hours before ultimate disposal. There should also be a washstand and basin just inside the door of the room and every person before leaving the room should be required to thoroughly wash and **disinfect the hands** with a 1 per cent. solution of **lysol** or other good disinfectant. Gowns should be put on upon entering the sick-room and taken off just before disinfecting

the hands and leaving the room. These gowns when soiled should be placed with other soiled linen in the tub of carbolic acid solution.

There should be a thorough surface **disinfection** of every room in the house in which a case of cholera or suspected cholera is found. This is secured by cleansing of the walls and floor with disinfecting solution ($2\frac{1}{2}$ per cent. **carbolic acid** or 1:1000 **bichloride solution**).

Convalescents should have three vibri-negative reports of stools on successive days before being discharged. A. J. McLaughlin (U. S. Public Health and Marine-Hosp. Service, Report No. 53, 1910).

During times of cholera epidemic, bacillus carriers are numerous, and the writer found from 6 to 7 per cent. of carriers among healthy individuals living in the infected neighborhoods in Manila. When cases are few—the so-called sporadic cases—hundreds and even thousands of stools may be examined before the first carrier is found. A. J. McLaughlin (N. Y. Med. Jour., Jan. 21, 1911).

For detecting cholera carriers, the author adds saccharose and sodium carbonate to the Dunham peptone solution until the medium is alkaline, phenolphthalein being used as indicator. If a moderate number of cholera vibrios are introduced, together with other organisms, the culture becomes decolorized after five to eight hours' incubation. The cholera vibrios ferment the saccharose, the acid produced unites with the sodium carbonate, and the medium becomes neutral; hence the red color of the phenolphthalein disappears. As a minimal number of cholera organisms introduced with a maximal number of other organisms do not readily decolorize the culture, the cholera vibrios should be enriched by preliminary incubation in Dunham's peptone solution. Bendick (Jour. Amer. Public Health Assoc., Dec., 1911).

Seventeen healthy bacillus carriers were found on 5 ships arriving in the harbor of Alexandria from other

Mediterranean ports; 3 of the ships had no cases of cholera on board. The bacillus carriers and those presenting the disease were always among the poorest and most crowded passengers. The disease broke out in several of the cases later than the incubation period of five days, accepted as the limit by the international convention. The healthy carriers lost their bacilli in 1 or 2 days when they were from ships free of cases of cholera, while the carriers who had been in direct contact with the sick kept the bacilli for 6 to 13 days. A. Panayotaton (*Grèce méd.*, Feb. 15, 1912).

The author holds that **abstention from nitrate-containing food** is the main point in *prophylaxis*, and, on suspicion of incipient cholera, advises sipping a 1 per thousand solution of **amidosulphonic acid**, which almost instantaneously transforms nitrous acid into free nitrogen. Emmerich (*Münch. med. Woch.*, Nov. 26, 1912).

Examination of a number of patients just before they left the cholera hospital revealed that about 36 per cent. of them were excreting the cholera organism in their stools and were therefore "carriers." Examination of 27 persons who had been in close contact with cholera cases showed that 6 were excreting the cholera vibrio in their stools and were apparently quite healthy at the time. Both these "contacts" and the convalescents are important agents in transporting cholera. The cholera vibrio was found on the external appendages of flies and also in their alimentary tracts. The main channels by which cholera infection is transmitted are healthy "carriers" and flies. E. D. W. Greig (*Indian Med. Gaz.*, Jan., 1913).

The writer calls attention to the efficiency of **anticholera vaccination** in the Balkan wars. Whereas the incidence of cholera among 14,332 unvaccinated officers and enlisted men was 5.75 per cent., that among 21,216 men vaccinated once was but 3.12, and among 72,652 men vaccinated twice,

0.43, according to Arnaud. In the civil population of Greece, Cardamatis reported percentages of 2.12, 0.26, and 0.01, respectively. The vaccine used in these cases had been prepared at the Pasteur Institute in Paris and consisted of cultures on agar heated to 60° C. for 1 hour. The writer considers 3 injections at 5-day intervals essential if immunity is to be acquired. Doses of 1, 1.5, and 2 c.c. respectively, should be administered. C. Dopter (*Paris médical*, Jan. 2, 1915).

In the Hungarian army the writer found cholera inoculation much less efficacious than the typhoid. Aside from its undetermined protective power, it did not mitigate the course of the disease. Fejes (*Deut. med. Woch.*, Apr. 6, 1916).

TREATMENT.—The tremendous mortality of Asiatic cholera is a most striking evidence of the relative futility of measures directed against the disease. **Rest in bed, warmth, the use of carbonated beverages, whey, egg-albumin, and peptonized milk** which has been previously boiled should constitute the sole **dietary**. A preliminary dose of **castor oil**, and **hot applications to the abdomen**,—either **spiced plasters** or an occasional **turpentine stupe**,—may be of some value. During the active stage of the disease, **opium** in some form is imperatively demanded. The hypodermic use of morphine is to be given preference. As little should be given by the mouth as possible. Frequent **washing out of the bowel**, either with a 1 or 2 per cent. **quinine bihydrochloride solution** or one consisting of **creolin** in 2 quarts of water, together with the use of normal **saline solution intravenously**, in an attempt to make up for the fluid lost, is especially indicated. During the stage of reaction it is necessary carefully to

regulate the **diet**; and in those cases in which colic and muscular cramps occur, to meet them by relaxing **warm baths** and, if required, the use of **opium**.

The indication to keep up the circulation and so re-establish the functions of the kidneys in cholera is met partly by the use of drugs. The following combination may be employed in doses of 20 minims (1.25 c.c.), in an ounce (30 c.c.) of water, every two, three, or four hours, according to the state of the pulse:—

℞ *Caffeina sodio-salicylatis* ... gr. iiss (0.16 Gm.).
Sparteina sulphatis gr. ss (0.03 Gm.).
Liquoris atropinae (B. P.) ℥j (0.06 c.c.).
Spiritus vini gallici,
 q. s. ad ℥xxx (1.25 c.c.).

Coldness of the extremities and profuse clammy perspiration are readily controlled by the **atropine**; in addition, **hot-water bottles** or **foot and body warmers**, **sinapisms** to the **calves**, and **friction of the limbs with dry ginger powder** are often resorted to. To encourage urinary secretion, **poultices of digitalis leaves** and **dry cupping** may be utilized.

The only nourishment allowable in cholera is **hot black coffee**, without milk or sugar. This may be given whenever the patient requires a drink, is usually retained, and quenches thirst better than cold fluids. Choksy (Lancet, April 30, 1907).

Following treatment of cholera found effectual in a large experience in Siam: The patient first receives from 4 to 6 tablets (at once) of the following composition:—

℞ *Cocaine hydrochloride* . gr. $\frac{1}{20}$ (0.003 Gm.).
Creosote ℥ $\frac{1}{8}$ (0.007 c.c.).
Cerium oxalate gr. ij (0.13 Gm.).
Pepsin gr. $\frac{1}{4}$ (0.016 Gm.).
Tincture of nux vomica. ℥ $\frac{3}{8}$ (0.02 c.c.).

This absolutely controls the vomiting in most cases. The patient is instructed to chew the tablets up thoroughly before swallowing.

From three to five minutes after the cocaine compound, 1 or 2 tablets of the following formula are chewed and swallowed:—

℞ *Morphine sulphate* gr. $\frac{1}{6}$ (0.01 Gm.).
Extract of hyosciamus gr. $\frac{1}{8}$ (0.008 Gm.).
Nitroglycerin . gr. $\frac{1}{100}$ (0.00065 Gm.).
Citrated caffeine gr. ss (0.03 Gm.).
Capsicum,
Camphor, of
 each gr. $\frac{1}{4}$ (0.016 Gm.).
Tincture of digitalis gtt. v (0.16 Gm.).

Every few minutes, until the pulse can be felt at the wrist, a tablet of **nitroglycerin**, $\frac{1}{100}$ grain (0.00065 Gm.) with 2 minims (0.12 c.c.) of the tincture of **digitalis**, is given.

As soon as the pulse is felt at the wrist, no matter how feebly, the prognosis becomes more favorable.

In the mean time the patient is given the following mixture:—

℞ *Tincture of eucalyptus* f℥iv (120 c.c.).
Spirit of camphor. f℥ij (8 c.c.).
Tincture of capsicum ℥xxx (1.8 c.c.).

This is taken at one dose diluted with an equal quantity of water, and from teaspoonful to tablespoonful doses of tincture of **eucalyptus** are given concurrently every hour until reaction sets in. **Mustard plasters** and the application of **heat to the body** are not neglected.

To keep the blood-serum in the vessels and thus prevent shock and dehydration, the author uses heroic doses of **tannic acid**. He has given 120 grains (7.8 Gm.) of pure tannic acid in twenty-four hours with the happiest results, administering 10-grain (0.65 Gm.) doses after every bowel movement, or, oftener, 20 grains (1.3 Gm.) every hour irrespective of bowel movement.

A great many patients promptly react as a result of this treatment, and then are attacked by suppression of urine, which often occurs at this time. To combat this he employs tincture of **eucalyptus** in addition to the **digitalis** and **citrate caffeine**, which also act as diuretics. The most vital thing in the treatment at this point is the **absolute prohibition of food** for thirty-six hours or longer. A relapse can occur from the eating of a slice of orange or a teaspoonful of soft-boiled rice. Braddock (Jour. Amer. Med. Assoc., June 15, 1907).

Ninety per cent. of the patients in a cholera epidemic recovered under the following treatment: **Sulphate of quinine** in 10-grain (0.65 Gm.) doses every hour until the rice-water stools disappear and bile is passed into the motions. For suppression of urine, **friction of the limbs**, **hot fomentations**, **dry cupping over the loins**, and **sweet spirit of niter**. When evidence of failing circulation intervenes, subcutaneous injection of **saline solution**. Ussher (China Med. Miss. Jour., May, 1908).

In the treatment of vomiting in cholera the following measures may be used: Internally: (1) **Calomel**, gr. $\frac{1}{6}$ (0.01 Gm.); **sodium bicarbonate**, gr. ij (0.13 Gm.), every hour up to three or four doses. (2) **Cerium oxalate**, effervescent, 1 teaspoonful every hour up to 2 or 3 doses. (3) **Thick barley water with lemon juice**. (4) Drop doses of **wine of ipecac** every hour. (5) **Chloretone**, gr. ij (0.13 Gm.) every hour up to 3 doses. (6) **Hot coffee** acts sometimes miraculously when other drugs have failed. Locally: (1) **Mustard plaster** 6 by 4 inches **over the epigastrium**. (2) **Mustard plaster** 2 by 1 inches just outside the angle of jaw **over the anterior margin of the sternomastoid muscle**, to stimulate the vagus. J. L. Chundra (Medico-Surg. Jour. of the Tropics, March 15, 1909).

The writers emphasize the importance of uremia as a sequela which the textbooks speak of as the "reac-

tion stage" or state of "cholera typhoid." The symptoms of this stage consist of a bounding pulse, labored breathing, flushed face, and coma. The severe cases of collapse may be expected to develop some uremia. The patient should be encouraged to **drink large amounts of water and of lemonade**. **Hot packs** may be used.

Of all measures used to induce the kidneys to secrete, large **rectal injections of hot saline solution** were most successful. Often enemata of 4 to 6 liters were given five or six times in the twenty-four hours.

Intestinal paralysis occurred in a few cases, and, as a rule, was very intractable. It sometimes was relieved by **hot turpentine stupes to the abdomen** over a long period, in connection with **hot saline enemata**, with the rectal tube left in for a variable period to draw off the water and gas. Later, small doses of **calomel** followed by **magnesium sulphate** were given, but, owing to the denuded condition of the intestine and the lowered vitality, these drugs sometimes produced a bad effect. H. J. Nichols and V. L. Andrews (Philippine Jour. of Sci., April, 1909).

Value of a large injection of **morphine** in cholera as soon as the disease is suspected emphasized. If persons sleep after an injection of $\frac{1}{2}$ or $\frac{1}{3}$ grain (0.03 or 0.02 Gm.) of morphine, their chances of recovery are good; morphine does not induce sleep in those patients who are badly collapsed, but only stops the diarrhea and vomiting. R. W. Burkitt (Jour. of Trop. Med. and Hyg., July 15, 1909).

Water or normal saline may always be **freely given by the mouth** in cholera, and, although it is frequently vomited some toxin is probably evacuated with it. Of much greater practical importance are **saline enemata**. When there is a fair pulse, a pint of saline by rectum every two hours will often suffice to tide the patient over the danger of collapse. In borderland cases, with a still clearly perceptible

pulse, but a blood-pressure nearly down to 70 mm., the author has used continuous rectal injections at the rate of 1 ounce a minute (3 pints an hour), with the desired result of raising the pressure and avoiding the necessity for the much more troublesome intravenous administration.

Injection of from $\frac{1}{2}$ to 1 pint of saline into the subcutaneous tissues of the chest, axilla, or thigh has been largely used in India. If there is a fair pulse the fluid is readily absorbed and will certainly save some cases; **subcutaneous injections** may therefore be recommended when the much more efficient **intravenous method** is not practicable. The great drawbacks are the difficulty of rapidly getting in sufficient fluid and the frequency with which the extensive abscesses result, in spite of the utmost care, on account of the low vitality of the tissues in cholera.

An easier way of introducing large quantities of **salines** into the system is by **intraperitoneal injections**. Leonard Rogers (Therap. Gaz., Nov. 15, 1909).

In each cholera epidemic the road tending to death must be studied. When people get rapidly livid, opiates must be avoided. What is sufficient at the beginning or end of an epidemic is not of any use in the middle-period type of the disease.

In the earlier milder cases the author has found **salol** and **benzonaphthol** very useful. Many, however, would probably have died in spite of salol, **chlorodyne**, etc., had he not resorted to **creolin**—4 to 6 drops, rolled about in flour with a stick, then turned on cigarette paper, gently enveloped in it, and swallowed. Four to 6 doses of this bolus were given, repeated every second or third hour. The drug must be used fresh.

Preparations of **ether**, **valerianate of ammonium**, **friction**, **counterirritation**, **packing in hot towels**, etc., are useful to bring about reaction, but the temperature must be carefully watched. Anything above 102° F. (38.9° C.) is already grave in cholera,

and not much should be done to bring about overreaction. Basil (Brit. Med. Jour., Sept. 24, 1910).

The cholera patient needs **complete rest in bed** and sleep should on no account be interrupted. The **extremities** need to be **kept warm with hot bottles or hot blankets**, and to prevent the great depression of surface temperature in the collapse stage the temperature of the room should not fall below 70° F., though ventilation should still be free. Thirst needs continuous treatment by the exhibition of small quantities of **iced water** or **milk and soda**, small lumps of **ice to suck**, or **rinsing of the mouth or lips with a weak solution of lemon juice**; large draughts should be avoided, for they accentuate the vomiting. Thirst may be lessened, and collapse at the same time guarded against, by subcutaneous infusion of **normal saline**. (The Hospital, Sept. 24, 1910.)

Sodium iodate given subcutaneously in 82 cases of cholera. One c.c. (16 minims) of a 7 per cent. solution was injected every three hours; in the case of children a 3 per cent. solution was employed. The mortality was 25.6 per cent., while in 343 cases treated otherwise it was 46 per cent. The injections are painless and cause no reaction. V. Ouflioujaninov (Prescriber, May, 1911).

Uremia in cholera can be prevented by administering rectal **saline** after the intravenous. *Persistent vomiting* is checked by dilute **hydrocyanic acid** and minute doses of **wine of ipecac**. *Hiccough* in one case persisted for six or seven days and finally ceased after a solution of **camphor** in alcohol (30 grains—2 Gm.—to the ounce—30 c.c.) on a lump of sugar had been given. *Hyperpyrexia* can be overcome by administering the **rectal saline injection cold**. *Ulceration of cornea* may occur. It is advisable to wash the patient's eyes frequently with **saline** and apply some form of ointment, especially **iodoform ointment** (2 grains—0.12 Gm.—to 1 ounce—30

c.c.). **Calomel** in minute and continued doses, up to 4 or 5 grains (0.26 or 0.3 Gm.), is useful in restoring the yellow color of the stools. If it fails a **mustard plaster over the liver** will be of assistance. G. B. Sarkar (Calcutta Med. Jour., June, 1911).

In the algid cases of cholera **hot baths** are of occasional use, frequently leading to cessation of diarrhea and vomiting and relieving the cramps. The latter are also helped by **rubbing the skin with brushes moistened with camphor or soap liniment**. Moderate diarrhea may be treated by **salol**, about 8 grains (0.5 Gm.), three or four times a day. This and the usual antidiarrheal diet frequently suffice. In more severe cases, where nausea is marked, but there is no vomiting, **ippecac** may be given and vomiting produced by giving much **warm water** and **tickling the fauces**. This treatment, of course, is more or less heroic and must be used with caution. If these methods do not relieve the diarrhea, constipating drugs, such as pure resublimed **naphthalin**, 2 to 8 grains (0.13 to 0.5 Gm.), or **benzonaphthol** in the same dosage several times a day, may be given. Calomel seems of use, but in very rare cases. A **Preissnitz compress** continued through the night may be used to quiet peristalsis. In cases of *cholérine*, **salol** was begun as above, and if the symptoms did not respond to treatment **hot baths** were begun. Their duration was fifteen to thirty minutes, and the temperature as hot as could be stood by the patient. G. A. Friedman (Med. Rec., Aug. 19, 1911).

In 1 case the author found it necessary to give 5 **hypertonic saline injections**, the total quantity of solution injected being 20 pints. The injection is made into a vein laid bare at the bend of the elbow, or, if there is difficulty in finding a suitable vein here, the large vein which usually crosses the internal malleolus may be chosen. A small silver cannula with a stopcock is tied into the vein, and connected by a rubber tube with a

pear-shaped glass receptacle, graduated in ounces up to 1 pint. The whole apparatus must be sterilized by boiling. The fluid is run in by gravity, and the rate of flow can be regulated by raising or lowering the flask, or by manipulating the stopcock. L. Rogers (Brit. Med. Jour., Sept. 16, 1911).

Potassium permanganate given internally with some success in cholera. Dose, 0.4 to 0.5 Gm. (6 to 7½ grains) *per diem*, dissolved in 400 to 500 Gm. (¾ to 1 pint) of pure water and given every half-hour. Drug continued two or three days in diminishing doses. Especially valuable in cases with hemorrhage. **Iodine tincture** given in 42 cases, with 34 recoveries. Dose, 40 to 60 minims (2.4 to 3.6 c.c.) daily, dissolved in 250 Gm. (½ pint) of distilled water, given every hour. **Copious bowel irrigations with warm iodine solution** or 1:1000 **potassium permanganate solution** also used with benefit in severe cases. J. Logotheti (Bull. méd., Dec. 6, 1911).

In cholera the author administers by rectum and intravenously the following **hypertonic saline solution**: **Sodium chloride**, 120 grains (8 Gm.); **potassium chloride**, 6 grains (0.4 Gm.); **calcium chloride**, 4 grains (0.26 Gm.); water, 1 pint (500 c.c.). The object is not only to replace the water and salts lost, but to raise the salts in the blood somewhat above the normal, so that the osmotic currents will tend to cause fluid to run into the blood rather than out, and the diarrhea will be checked instead of increased, as it is by the use of normal saline. Rogers (Proceed. Royal Soc. of Med., Dec., 1911).

Intraperitoneal saline injections recommended in cholera. A blood-pressure which falls below 70 continues to fall rapidly, as a rule, to between 30 and 40, and preparations for the injection are made as soon as the pressure is below the first figure. A trocar-cannula specially made is used. The site of the puncture, just below and a little to one side of the

umbilicus (where the peritoneum is attached to the posterior surface of the anterior abdominal wall) is marked by the application of a small pure phenol swab, drawn quite taut, and the spot brought into the middle line immediately below the umbilicus. The previously sterilized trocar-cannula is thrust in. Hypertonic solution is then allowed to run in at the rate of about a pint in four or five minutes, the temperature being regulated in the same way as for the intravenous method. A fair clinical indication of when to stop is when the patient experiences a desire to micturate. Micturition, though attempted, does not ensue at this point, but generally coincides with the return of the blood-pressure in the radial artery some few hours later. T. H. Bishop (*Indian Med. Gaz.*, April, 1912).

Vasoconstrictors, such as adrenalin, digitalis, and caffeine, must be avoided in cholera. A sufficient amount of fluid must be maintained in the circulation to insure a free supply to the kidneys.

Nitrites constitute the sheet anchor for the latter purpose, after the **intravenous injection of hypertonic saline** to combat collapse. G. B. Sarkar (*Practitioner*, Nov., 1912).

In an experimental study of the action of cholera endotoxins on the adrenals of rabbits, the writer found that it caused disappearance of the normal chromaffin staining reaction. Again, an extract prepared from the adrenals of animals injected with an emulsion of cholera vibrios killed at 60° were found to contain little or no adrenalin. C. A. Demetrescu (*Réunion Biol. de Bucharest*, Dec. 17, 1914).

In keeping with the views of Sajous (1903-1907), Drake-Brockmann (1910), Piovesana (1912) and others, the writer found a striking analogy between the cholera syndrome and the symptoms from defective functioning of the suprarenals. The remarkable tolerance of cholera patients for **adrenalin** shows, moreover,

that it supplies a much needed active principle. He injected it subcutaneously in doses of 0.004 or 0.006 Gm. ($\frac{1}{15}$ or $\frac{1}{10}$ grain) in the 24 hours, keeping it up for several days, supplemented by **saline infusion**. Others have found it very efficient. Naamé (*Presse méd.*, Dec. 10, 1914).

In the presence of an epidemic it is especially necessary, in so far as is possible, to avoid fatigue, worry, fear, and injudicious dieting. Alcohol, unboiled water, purgatives, and the use of uncooked food and especially foods prone to decomposition, as crabs and shellfish, must also be avoided. The use of vaccines has already been alluded to. No serum has thus far been produced which will yield definite results.

INTESTINAL INFARCTION (Including Embolic and Thrombotic Obstruction of the Mesenteric Arteries and Veins).

In acute endocarditis, and even in the course of chronic endocarditis, infarcts are not uncommon, particularly in the spleen and kidneys; less often they occur in the brain, not seldom in the lungs, and occasionally few or numerous ones are found in the intestines. In recent cases the infarcted area is apt to suppurate because of the mycotic emboli; thus, numerous miliary abscesses may occur. Embolism of the mesenteric arteries, usually the superior, may occur in arteriosclerosis, aneurism, or endocarditis, and an ischemic process or hemorrhagic infarction of the small intestine follows. Thrombi may form in the mesenteric veins either as a result of a general infection or occasionally in intestinal ulcers or appendicitis, and especially in that severe complication of the lat-

ter condition, namely, pylephlebitis. They may also form in hepatic cirrhosis, in the cachexias, the grave anemias, and after embolism. Rarely, when the involved area is small, a collateral circulation may be established, but in the majority of instances gangrene results.

Case of embolism of superior mesenteric artery in which death occurred before the intended operation could be performed. The superior mesenteric artery was occluded at a point between the colica media and colica dextra. The portion of the duodenum supplied by the gastroduodenalis was not involved, but the entire small intestine except the duodenum was gangrenous. F. A. Carmichael (Jour. Amer. Med. Assoc., Feb. 26, 1910).

Case of anemic infarct of the small intestine in a man of 70. The arteries of the intestine showed an old obliterating endarteritis that had caused an acute thrombosis. The veins showed a similar condition. W. R. Meyer (Centralbl. f. allg. Pathol. u. pathol. Anat., March 15, 1913).

In thrombosis of the mesenteric artery **purgation** will always produce an effectual result, thus ruling out intestinal obstruction. Report of a case of pancreatitis with thrombosis of the mesentery and accompanying gangrene of the gut. There was no suspicion of previous endocarditis. Extravasation of fluid with pancreatic enzymes into the peritoneal cavity during the recurrent attacks of pancreatitis may have led to destruction of mesenteric tissue, with resulting mesenteric thrombus. Ernest Laplace (Penna. Med. Jour., June, 1913).

The symptoms are of sudden onset, consisting of abdominal pain, nausea, vomiting, and bloody flux or obstinate constipation, with abdominal distention and collapse. Death usually follows in from one to three days.

Suggestion that thrombosis may occur in the small vessels of the mesentery at least as often as in the large. Report of several cases. Stalley (St. Paul Med. Jour., Aug., 1913).

Mesenteric vascular occlusion is not an extremely rare condition. The writers who report 3 cases, found about 400 recorded in the literature. The occlusion is most frequently in the arteries. By far the most common lesion produced is hemorrhagic infarction of the intestine. The most common cause of the occlusion is embolism resulting from infection and injury. There is no difference clinically between the arterial and the venous occlusion, regardless as to whether it is due to embolism or thrombosis, in the superior or the inferior vessels. The clinical diagnosis should be made on sudden onset, acute colic-like abdominal pain, distention and tenderness, signs of shock and collapse; often there may be vomiting and constipation; if diarrhea is present, it is almost always accompanied by melena. Eisenberg and Schlink (Surg., Gynec. and Obstet., July, 1918).

The diagnosis is always difficult, but may be aided by the recognition of the various possible etiological factors, in the absence of which a diagnosis of acute pancreatitis or intestinal obstruction is usually made.

Case of thrombosis of the superior mesenteric artery simulating an abdominal tumor. A man aged 67 years was admitted for urinary disturbances due to an enlarged prostate. Later he had a suppurative orchitis and perineal abscess. About a month later, during dressing of the wound, he was seized with violent pain located below the false ribs, and radiating to the sternum and lower limbs. There was no nausea or vomiting, no stool since the night before, and no tympanites. At the site of greatest pain, a movable mass the size of two closed hands was palpated. Its dullness was continuous with that

of the liver. On the third day death occurred. At autopsy there was found a mass of intestinal loops, violet black in color and distended, corresponding in position to the mass felt in the abdomen before the opening was made. In a branch of the superior mesenteric artery there was found a grayish adherent clot. Thévenot and Rey (*Arch. gén. d. chir.*, vol. v, p. 1234, 1911).

The sequence of the two contradictory symptoms, diarrhea and ileus, is of diagnostic import in mesenteric embolism. In the author's case the chief complaint was an obstinate, fetid diarrhea. The patient was atheromatous and cachectic, and succumbed in a few days. The autopsy showed thrombosis of the mesenteric veins and gangrene of portions of the jejunum, ileum, and colon.

Eleven of 24 patients with mesenteric embolism recovered after **enterectomy**—45.8 per cent. The author encountered a number of cases of "curable" intestinal embolism in debilitated men with pneumonia or bronchitis. The edema and small infarcts in these cases are liable to subside spontaneously, but they are probably the source of sclerous stricture of the intestine, and probably have some connection with the attacks of pain in the syndrome of intestinal arteriosclerosis. E. Boinet (*Bull. de l'Acad. de Méd.*, Jan. 16, 1912).

The following points are rather suggestive in infarct of the small intestine: 1. Sudden abdominal pain occurring in a patient beyond the third decade, the pain being either very violent from the very beginning or becoming progressively worse for several days. 2. Intense suffering, often with writhing on the bed and nervous symptoms remotely suggesting hysteria, combined with lack of rigidity and distention and a comparatively normal pulse and temperature. 3. Bloody vomiting and stools. 4. Demonstration of a source from which an embolus may have been derived, viz., endocarditis, phlebitis, etc.

Hempelmann (*Interstate Med. Jour.*, Feb., 1912).

Unless operative resection is feasible, death is inevitable, and in the septic cases it is practically inevitable in any event.

Massage is particularly dangerous where mesenteric thrombosis or embolism is suspected. **Exploratory laparotomy** is indispensable. Tschudy cured a patient by **packing with gauze** to shut off the infarcted region, keeping the abdominal wound open. In 6 other cases an artificial anus was made, but none survived the embolism. Kölbinger has reported a case in which **gastroenterostomy** was done after resection of the infarcted loop, with recovery of the patient. Thrombosis of a mesenteric vessel has been observed in a month-old babe, and in 2 children of 5 and 8, but the majority of patients are between 30 and 60. D. G. Zesas (*Centralbl. f. d. Grenzgeb. der Med. u. Chir.*, Aug. 13, 1910).

Case of mesenteric occlusion in a boy of 15 who four days before had sustained a hard blow in the stomach. On opening the abdomen several coils of ileum were found, distended, deeply cyanosed, and with a rather sharp line of demarcation at either extremity. The mesentery was succulent and hemorrhagic in spots. Resection of 40 inches of the infarcted intestine was accomplished by **end-to-end anastomosis** with Murphy button. The patient recovered and was well thereafter, excepting for a slight tendency to diarrhea. The age of the boy, the exclusion of any known source of embolism, the acute onset following trauma, the definite wedge-shaped area of infarction, the non-pulsating arteries, and the condition of the veins, all substantiated the diagnosis of thrombosis of a branch of the superior mesenteric artery due to trauma. E. C. Thompson (*N. Y. State Jour. of Med.*, April, 1911).

Of 68 cases operated upon for occlusion of the mesenteric vessels, 12 recovered, i.e., 82 per cent. mortality. Of 29 cases operated upon for arterial

mesenteric embolism 3 recovered, and of 39 operated upon for venous thrombosis 9 survived. The author advises spinal analgesia, **resection** as far as possible within healthy tissues, **evacuation of the stagnating intestinal contents**, **complete closure of the divided ends of the gut**, and **lateral anastomosis** as far away from the closed ends as possible. J. Gobiet (Wiener klin. Woch., Nov. 9, 1911).

INTESTINAL ULCERS.

Ulcers may occur in any portion of the intestine, from duodenum to rectum, and vary in gravity from the simple follicular ulcers already mentioned under catarrhal enteritis to the extensive sloughing ulcers of dysentery. They may be single, as is usually the case in the duodenal ulcers, or multiple,—even confluent,—and vary in their site according to the condition producing them. They vary also in their course, being acute or chronic according to the nature of the cause.

DUODENAL ULCER.

DEFINITION.—An ulcer usually in the first or second portion of the duodenum, small, round, ovoid, or occasionally irregular in outline, with a tendency to perforate, and in many instances markedly chronic in course. This ulcer essentially belongs to the type known as peptic ulcers.

Peptic ulceration found in 7.7 per cent. of 5884 adult cadavers: 1.5 per cent. were in the duodenum; 6.7 per cent. in the stomach; 0.1 per cent. in the esophagus. In 17 per cent. of the 140 cases of peptic duodenal trouble perforation was the cause of death. In 75 per cent. the ulcer had been overshadowed by some other affection. Latent peptic ulcer occurs comparatively frequently in persons with arteriosclerosis, and may first manifest presence by a severe open or prolonged occult hemorrhage. Gruber

(Mitteil. a. d. Grenzgeb. der Med. u. Chir., Bd. xxv, Nu. 3, 1912).

SYMPTOMS.—Until recent years this condition was entirely overlooked, and perhaps is still too frequently today.

[According to Mr. Moynihan, duodenal ulcer was first recognized by Mr. Travers, whose first cases were published in 1817. Abercrombie seems to have been the first to suggest the possibility, during the life of the patient, of the recognition of duodenal ulcer. Again quoting from Mr. Moynihan, the first case of perforating ulcer of the duodenum successfully treated by operation was reported in the British Medical Journal by Mr. H. P. Dean, in 1894. Moynihan's first case was operated on in June, 1900. It is interesting to note that one of the cases reported on by Mr. Travers occurred in a man of strumous habit, and this is an etiological factor to which, I believe, insufficient attention has been paid.]

Both gastric and duodenal ulcer are especially prone to occur in people with a family predisposition to tuberculosis. Though manifesting no definite evidence of tuberculosis themselves, their history and physical conformity lead one to regard such cases at least as suspects.

Case of duodenal ulcer in an atrophic infant 3 months old. There was a rapid pulse with subnormal temperature, the stools became bloody under observation, and the diagnosis was made before death. H. Flesch (Jahrb. f. Kinderheilk., Nov., 1912).

Analysis of a series of 486 patients with duodenal lesions showed that six were cancerous and 480 were benign ulcers, a ratio of 1 to 80. In a series of 780 patients with gastric lesions 240 were found to be cancerous and 540 were benign, a ratio of 1 to 2¼. The writer had 6 cases of carcinoma of the duodenum, and about 240 cases of carcinoma of the stomach, a ratio of 1 to 40, largely verified

by necropsy or operation. In a series of peptic ulcer cases, duodenal ulcer had been diagnosed 480 times and gastric ulcer 540 times. J. A. Lichty (N. Y. State Jour of Med., Nov., 1918).

According to Moynihan, there are few diseases in which the symptoms appear in such definite and well-ordered sequence. He admits that in some cases the usual order of symptoms fails, or that occasionally, on account of the exaggeration of one symptom, the value of the others may be dwarfed or destroyed, but this he regards as exceptional.

Of great importance is the history, as already stated. The patient will usually complain also of symptoms which he speaks of as indigestion, acid dyspepsia, or sour stomach, and very suggestive is the statement that this has lasted over some years, with alternate improvement and relapse. Moynihan insists that these symptoms are apt to be more marked and occasionally only present during the cold, damp seasons. During the active periods of the ulcer, according to him, the most important diagnostic feature is the so-called "hunger pain." This was first noted by John Abercrombie, in 1830. In some instances this is extremely marked, pain coming on from two to four hours after a meal and being relieved by the taking of food. If the diet be light, and especially if it is liquid, pain is apt to occur earlier; the converse of this is likewise true.

When a duodenal ulcer has undergone cicatricial contraction, the symptoms are those of retention and delayed motility, proportionate to the stenosis and duration of the lesion. On this point Hertz, in his little work on the "Sensibility of the

Alimentary Canal," makes the following statement:—

"Frequently, but by no means invariably, an ulcer near the cardia gives rise to pain immediately after meals and an ulcer near the pylorus about an hour and a half to two hours after meals, intermediate situations being associated with intermediate times. The time of onset of pain in duodenal ulcer is much more constant; it almost always begins between two and three hours after a meal. The time relations can be explained by considering at what moment free hydrochloric acid comes into contact with the ulcer so as to lead to an exaggeration of the reflex motor efforts which produce pain. The hydrochloric acid is secreted mainly by the glands of the proximal two-thirds of the stomach, the secretion of the extreme pyloric end being actually alkaline. As no peristalsis and consequently no churning of the contents occur in the fundus, the outer layer of chyme remains constantly very acid. A cardiac ulcer is therefore bathed in acid gastric juice at a very early stage in digestion. The food which first reaches the pyloric end of the stomach is alkaline; it is only after a considerable interval that the acid gastric juice reaches this part to any great extent, and as peristalsis is constantly active in the pyloric part, the gastric juice is greatly diluted by the large quantity of food with which it is mixed. Consequently an hour or more may pass before there is sufficient free acid to irritate an ulcer near the pylorus."

In only 123 of the author's 160 cases of chronic duodenal ulcer were the symptoms characteristic; the others suggested gall-stone trouble or gastric

ulcer. Hunger pain was present in all but 20 of 146 cases; in the intervals the patients felt entirely well. Anger, chilling, and overwork are liable to bring on an attack. In one group there was absolutely no pain at any time, the symptoms consisting merely of attacks of dilatation of the stomach with vomiting, alternating with intervals of complete health. There was excess of free acid and the total acidity was high; the opposite is the rule in cases with similar symptoms due to gall-stone or coprostasis. J. Sherren (*Berl. klin. Woch.*, July 14, 1913).

The writer reports 4 fatal cases, because they represent a group. The infants had the same environment, and they suggest an epidemic form. The deaths occurred during a period of 6 months. Very little of value was obtained from the family and personal histories. The infants were on the same milk formula that had been used by many others, but were anemic and poorly nourished. Three of the four were males. Their ages varied from 41 days to 7 months and 7 days. Diagnosis: (1) pain on taking food, (2) uneasiness, (3) distended abdomen, (4) edema, (5) blood in vomitus or stools, (6) perforative symptoms. Undoubtedly many cases are undiagnosed, as 11 cases reported by Entz were not diagnosed during life. W. H. Bartrain (*Wisc. Med. Jour.*, xvi, 85, 1917).

The finding of occult blood in the stools of patients with a suggestive history warrants a diagnosis of duodenal ulcer. Extraintestinal sources of bleeding must be ruled out, as hemorrhoids and vaginal discharges in women. The writer gives a list of 32 cases where a diagnosis was made on occult blood findings in the feces and where the diagnosis was confirmed at operation. The examination of the stools should include the guaiac test, the benzidin test, spectroscopic search for hematin, and microscopic search for hemin crystals. A. J. P. Pacini (*Med. Record*, Dec. 1, 1917).

The writer calls attention to the frequent co-existence of appendicitis with gastric and duodenal ulcers. In 36 laparotomies for ulcers and pyloric stenosis, the appendix was found diseased in 12 cases (33 per cent.); 18 out of 40 cases operated upon for juxtapyloric or duodenal ulcers showed chronic appendicitis (45 per cent.).

The author also observed that about 80 per cent. of his gastric ulcer patients were seized with pulmonary tuberculosis, generally benign and of slow evolution.

Almost every patient presented what the author calls the "pneumo-gastric sign," *i.e.*, pain on pressure at the level of the cervical pneumogastric. He infers that this is a neuritis of the vagi nerves of pulmonary origin, originating from the gastrointestinal distribution of these nerves, which causes trophic disturbances and thence ulcers and other chronic inflammatory injuries of the intestinal tract. Dubard (*Lyon chirurg.*, xv, 356, 1918).

During the active phase also, the patient is likely to complain of a sense of epigastric oppression, weight, and distention, especially an hour or more after the taking of food. Duodenal cases are prone to manifest nervous phenomena similar to those with which we are familiar in cases of hyperchlorhydria, *viz.*, insomnia and general irritability. Loss of weight may occur. Owing to the fact that the pain comes on some time after a meal, it is not unusual for these patients to take a light meal at bedtime or to keep biscuits at the bedside. Relief is often obtained by abdominal pressure; hence the tendency to lie in a prone position. The appetite is, as a rule, very fair, often good. Nausea and vomiting are the exception. During the quiescent period, which may extend over weeks, months, or even

several years, absolutely no symptoms may be complained of. Suddenly there may be a return, and occasionally the vomiting of blood, or tarry stools, or evidences of perforation may announce the advent of serious complications.

The symptoms of duodenal ulcer are as follows: The patient states that he has certain definite attacks, nearly always worse in winter than in summer, and very apt to be precipitated by a chill. From two to two and a half hours after breakfast he is fairly comfortable. It is his best time. Then he has a feeling of discomfort in the epigastrium; he feels full and heavy, and may get some relief from the belching of gas. Some of these patients bring up a very sour fluid, which tastes very bitter and acid and makes the mouth dry and the teeth chalky. This pain gradually increases until the next mealtime comes. The patient sleeps comfortably until he wakes about 2 A.M. He gets relief from nibbling a biscuit, which he keeps at the bedside. The pain is found to be most relievable by something stodgy and indigestible. Taking an alkali relieves the pain; so will emptying the stomach by washing it out. If these symptoms are recurrent one can diagnose duodenal ulcer. Moynihan (*Med. Press and Circular*, July 22, 1908).

Almost without exception the ingestion of any substance, and even acids, causes the pain to stop immediately in duodenal ulcer. The average total acidity (100 cases) is 77, and in 70 per cent. there is a hypersecretion. The cause of the pain in gastric ulcer is the HCl contained in the gastric juice coming into contact with ulcerated surface after it has passed into the duodenum. Ulcer of the duodenum reflexly excites the secretion of gastric juice. The relief of the pain follows the ingestion of any substance into the stomach. Food taken into the stomach excites a reflex secretion in the duodenum. This secretion is of

sufficient quantity in concentration to neutralize the HCl of the gastric juice. J. T. Pilcher (*Long Island Med. Jour.*, Sept., 1911).

In the presence of a duodenal ulcer near the pylorus, if the patient drinks a pint of milk during the attack of pain the latter keeps up in the same intensity for five, ten, or fifteen minutes; then suddenly the patient belches some gas and in a minute the pain is over. This occurs regularly. When the ulceration is in the stomach itself, the patient feels relief of the pain after a few swallows of milk and gradually all pain subsides. With duodenal ulcer, roöntgenoscopy shows that the pain ceases as the milk passes into the duodenum. Meunier (*Presse méd.*, Feb. 7, 1912).

Pain in duodenal is not so acute as in gastric ulcer, and remissions of several weeks are the rule. The hunger pains which come on 4 hours after meals are characteristic. It may wake the patient up after midnight. Conversely, in gastric ulcer the pain is usually increased by the intake of food, and soda relieves it. Koehler and Walker (*Northwest Med.*, xv, 58, 1916).

DIAGNOSIS.—Physical examination of the abdomen in all cases presenting gastric or intestinal symptoms deserves very much more attention than has hitherto been given to it. Its actual value can, of course, only obtain confirmation when symptoms, reflex phenomena, and the lessons learned by operative interference are carefully correlated, or, in addition, by the findings at necropsy.

The enlargement of the duodenum in duodenal ulcer is apt to induce a characteristic tympanitic percussion sound over the quadrate lobe of the liver. This is caused by the dilated duodenum passing behind this lobe. It appears only when the liver is in its normal place, and when the dullness over the left lobe of the liver can be distinguished from the cardiac

dullness. The colon must be emptied before percussing. Günzburg (*Deut. med. Woch.*, July 14, 1910).

In some cases the duodenal ulcer causes no distinct subjective symptoms; sometimes weakness and pallor are the only signs of trouble. In 2 girls of 12 and 14 the associated anemia had been ascribed to their rapid growth. Examination of the stools in these cases first revealed that the anemia was secondary. In 9 cases out of 16 there was tenderness above the umbilicus toward the parasternal line. In 8 cases there was another tender point at the back, over the right twelfth dorsal and first lumbar vertebræ. In a few cases there was a zone of tenderness corresponding to the location of the duodenum, but this rapidly disappeared when the patient kept in bed. Pewsner (*Archiv f. Verdauungs-Krankh.*, Oct., 1911).

The way in which the pains of duodenal ulcer spread to the right side, the tender point to the right of the median line above the umbilicus, with reflex rigidity of the upper segment of the right rectus, and the accelerated expulsion of the stomach content, are all characteristic. Schütz (*Wiener klin. Woch.*, Oct. 10, 1912).

According to MacKenzie ("Interpretation of Symptoms"), owing to the autonomic cerebrospinal reflex, one finds cutaneous hyperesthesia, hyperalgesia, and more or less muscular rigidity, occurring in the mid-line between the xiphoid and umbilicus, in all active cases of gastric and duodenal ulcer. He further states that in ulcer of the cardia these phenomena, more or less marked, occur at the upper extremity of the xiphoid-umbilical line. In ulcers in the median portion of the stomach they are lower down, in pyloric ulcer still lower, and in ulcers of the duodenum these reflex signs are just above the umbilicus. To elicit them, one should

be extremely light of touch, as a heavy hand results in the production of rigidity and more or less discomfort even under normal conditions, though, of course, without cutaneous hyperesthesia or actual hyperalgesia (the latter being examined for by pinching the skin).

The laboratory findings are not of very great value in the diagnosis of this condition. Hyperacidity and excess of free hydrochloric acid may be present in several states other than ulcer, and in ulcer the findings may be normal or even subnormal as to acidity, total or free. Hypersecretion may likewise be present. When hyperacidity occurs, however, it is most apt to be present in the acute phases.

Of 529 cases of duodenal ulcer, 48 per cent. presented normal acidity, 35 per cent. hyperacidity, and 16 per cent. subacidity; hyperacidity was more frequently observed in males and subacidity in females. Pain was present in 96.5 per cent., and was most prominent in cases with hyperacidity. Friedenwald (*Amer. Jour. Med. Sci.*, Aug., 1912).

The clinical diagnosis of duodenal ulcer has been chaotic until recently. The change of opinion as to the frequency of duodenal ulcer has been very remarkable during the last 2 years. Most of the ulcers in the vicinity of the pylorus which had been called pyloric ulcers are in reality duodenal. Gastric ulcers in the terminal 1½ inch of the pylorus may be mistaken for carcinoma on account of the tumefaction due to edema and muscular hypertrophy. The writer's statistics show 73 per cent. duodenal ulcers to 27 per cent. gastric ulcers. In typical duodenal ulcer the history is the most important diagnostic feature, the röntgenogram second, the physical diagnosis including the use of the stomach tube third, and the laboratory diagnosis a poor fourth. W. J. Mayo (*Med. Rec.*, June 12, 1915).

As to the value of X-ray examinations, I quote again from Hertz: "In a series of cases of duodenal ulcer examined with the X-rays, I have always found that the stomach begins to empty itself immediately after the food has been swallowed and that the evacuation is at first rapid. When the pain begins between two and three hours after a meal, only a small proportion of the food is still present in the stomach, and the hypertonic condition constantly present in cases of duodenal ulcer reaches its greatest development, owing to the increase in tone which occurs as the bulk of the gastric contents diminishes. Under these conditions peristaltic contractions can produce a complete separation of the pyloric part from the rest of the stomach at a considerable distance from the pylorus. Owing to the excessive and prolonged secretion of normal gastric juice, which is the cause of the so-called hyperchlorhydria of duodenal ulcer, the proportion of gastric juice and of hydrochloric acid in the chyme increases as digestion proceeds. At first most of the acid combines with alkaline salts and the proteins of the food, and the small quantity of free acid which reaches the duodenum is rapidly neutralized by the alkaline intestinal juice, bile, and pancreatic juice, so that the relaxation of the pylorus is only occasionally inhibited. But after two or three hours, the proportion of acid present being greater, some of it reaches the ulcer before it is neutralized. The inhibition of pyloric relaxation, which the contact of acid with the intact duodenal mucous membrane produces, is exaggerated by the presence of the ulcer, so that the peristaltic waves advance

against a pylorus, which only opens at considerable intervals in order to permit the passage of a small quantity of hyperacid chyme into the duodenum. Immediate relief to the pain follows the administration of alkalis or proteins, which neutralize the acid, or of food or water, which dilutes it; relief is also produced by vomiting and lavage, which remove the acid and at the same time empty the stomach so that nothing is left upon which the muscular coat can contract. The pain disappears spontaneously only when the stomach has become completely empty. This generally occurs about an hour after onset of pain, but if the evacuation of the stomach is hindered by partial obstruction due to cicatrization or inflammatory swelling round the ulcer, the pain lasts for many hours. As the sense of fullness is produced by exactly the same mechanism as pain, when the stimulus is less powerful, a sensation of fullness is generally felt between two and three hours after food for some months before the first occurrence of pain. At a later stage pain may be replaced by this sensation after some meals, and, as Moynihan has pointed out, the characteristic hunger pain is preceded and accompanied by a sensation of fullness, distention or weight in the same situation. I have already explained how the patient often erroneously ascribes this to flatulence and repeatedly tries to eructate, temporary relief being at last obtained by the return of some of the air swallowed in the preceding unsuccessful attempts. The salivation which often occurs when the pain is most severe is an additional cause of the aërophagy."

Gastric hyperacidity is present in 40 per cent. of cases of duodenal ulcer. Permanent hyperacidity indicates an organic, not a functional, affection. There is increased pyloric peristalsis, best observed by means of the X-rays after a bismuth meal. The pain usually occurs when most of the food has reached the duodenum. Delayed emptying of the stomach is rare in early duodenal ulcer. Blood is usually found in the stools if the latter be examined daily for some time. Occasionally the evidences of stenosis due to scar-tissue may present themselves in support of the diagnosis. B. G. A. Moynihan (*Lancet*, Jan. 6, 1912).

Ulcers on the anterosuperior surface of the duodenum differ very markedly in character from those on the posterior wall. Cases showing the callous round posterior ulcer give much longer histories, are not so acute in the differentiation of the cardinal diagnostic factors, do not suffer so much acute distress, but complain of a more continued discomfort, which, in turn, is not affected so definitely by the intake of food, and usually causes the maximum of duodenal deformity, and, consequently, the greater degrees of stenosis. Further, they are much more easily demonstrable in a radiogram. The anterior small ulcerations evidence the more typical syndrome, seldom cause much deformity or stenosis, usually bleed more easily, continuously, and freely, and are seldom diagnosticated by X-ray. J. T. Pilcher (*Med. Record*, July 26, 1913).

In duodenal ulcer X-ray study shows an excessive motility of the stomach, with rapid evacuation of the contents, the greater portion being emptied out within the first half-hour; there is also hypermotility of the duodenum, with formation, usually of a vacant area, which remains fixed in all of the X-ray examinations. By means of the X-ray one can positively rule out the presence of a duodenal ulcer by observation that the greater

portion of the stomach contents remains after an hour. One can also determine the degree of healing of an ulcer.

When the patient is given the **rest** treatment and placed upon the proper **diet** all symptoms will gradually disappear, and the patient will become, comparatively speaking, well. This usually takes place in from four to five weeks. At the end of this time, however, if a second bismuth examination be made, one will usually find the same characteristic signs present as in the fresh ulcer. If treatment is then further continued, as the ulcer continues to heal the motility of the stomach returns to a more normal condition, and by making repeated observations over a long period of time one can observe by the X-ray when the ulcer is healed. Julius Friedenwald and F. H. Baetjer (*Amer. Jour. Med. Sci.*, Oct., 1913).

Anemia and occult bleedings are capable of recognition by examination of the blood and stools. This should never be overlooked. Hematemesis and melena must be looked upon as late phenomena and essentially complications.

If hunger pain is present in an individual who is irritable, with more or less insomnia, a history of acid eructations, and especially if occult blood is found in the stool, the diagnosis is comparatively simple. The X-ray examination in some instances furnishes collateral evidence. In the long-standing cases symptoms may be absolutely quiescent for a greater or less length of time, after which hemorrhage, melena, or perforation suddenly develop. The sex—the condition being more common in men—and the age,—most common between 30 and 50,—as well as the ancestral and collateral tuberculous history, are likewise factors of importance.

The following points suggest duodenal ulcer perforation rather than appendicitis: (1) Onset of pain more sudden and violent and more initial shock; (2) contracted, concave, board-like abdomen; this is very characteristic, though some cases of appendicitis show it too; (3) tympany over the normal area of liver dullness when present almost diagnostic; (4) most of the patients are males between 20 and 40 years. E. A. Codman (Boston Med. and Surg. Jour., Feb. 13, 1908).

After mistaking gall-stone cases for duodenal ulcer, the author, on talking matters over with the patients, found that those with gall-stones nearly always had a spasm of the diaphragm with a catch in the breath in an attack of pain, a symptom which he believes to be absolutely significant. Another indication of gall-stones is a jaundice, too light to be evident to the naked eye or in the stools or urine, but perceptible in the blood as a deepening of the tinge of the serum after the corpuscles have settled in a capillary tube. B. G. A. Moynihan (Med. Press and Circ., July 29, 1908).

Jaundice occurs in a considerable number of cases of duodenal ulcer, usually in transient attacks, probably due to inflammation of the mucous membrane of the duodenum started up by the presence of an ulcer. Vomiting is somewhat characteristic. It is noted only in the acute attacks when the pylorus is temporarily disabled. When cicatricial obstruction occurs it corresponds to the type of obstruction, whatever be its cause. The vomiting during the acute attacks lasts but a few days, comes on at the height of pain, and the vomitus shows complete digestion. Only in case of associated obstruction does it show the presence of food taken at a long interval before. Cases diagnosed as gastric ulcers which give a history of pain and distress off and on for a long time before vomiting begins to be a symptom, are almost always duodenal. Long-continued, painful dyspepsia, with occasional at-

tacks of pyloric symptoms, is the important combination to look for in duodenal cases. Codman (Boston Med. and Surg. Jour., Nov. 25 and Dec. 2, 1909).

Report of 5 cases of duodenal perforation. Each occurred in a man in the prime of life and each patient had been in good health up to the time of the disaster. Previous indigestion is unusual in duodenal ulceration. This symptom never has the same prominence as in cases of perforated gastric ulcer. The onset of pain is sudden and entirely without any exciting cause. Gentle palpation reveals the upper part of the right rectus a little more tense than the corresponding part on the left, while there is a definitely tender spot above the umbilicus and to the right of the middle line. A new and misleading symptom then appears, the patient complaining of pain in the right iliac fossa. Many cases of acute duodenal perforation are thus diagnosed as acute appendicitis. This may be avoided if one remembers that in acute appendicitis the pain, tenderness, and rigidity are limited to the lower part of the abdomen. Another misleading feature in acute duodenal perforation is the subsidence of the abdominal symptoms as the initial shock passes off. D'Arcy Power (Lancet, July 13, 1912).

Tumors or ulcer in the body of the stomach may induce symptoms simulating those of duodenal ulcer. Determination of the exact site of the pain is quite important as well as the way in which the pains radiate. They extend to the left more with gastric ulcer, while the radiation is toward the right shoulder and arm and liver region with ulcers near the pylorus or in the duodenum. There was no pain on pressure in 20 per cent. of the author's duodenal cases, in 9 per cent. of pylorus ulcers, and in 10 per cent. of gastric ulcers, but there was diffuse tenderness in the epigastrium in 25, 27, and 40 per cent., respectively, and circumscribed tenderness below the xiphoid process in 10, 18, and 20 per

cent., respectively. A. Sommerfeld (*Archiv f. Verdauungs-Krankh.*, Feb., 1913).

Of 4 cases of duodenal ulcer in infants, all were found just below the pyloric ring and on the posterior wall. They averaged 1 c.c. in diameter. They were all round, punched out; there was no inflammatory reaction, and no signs of repair. Schmidt has reported 20 cases of duodenal ulcer in 1109 autopsies in infants in the first year. In about one-fifth of the cases perforation had taken place. A casual connection has been assumed between duodenal ulcers, marasmus, and infantile atrophy; the author regards this connection as accidental. Collins has reported a frequent association of duodenal ulcer with nephritis. In Schmidt's 20 cases the diagnosis was made only twice during life. In many instances the only symptom of peritonitis was acute collapse followed in a few hours by death. Vomiting of blood, either clear or of coffee-ground material, was seen in a small proportion of cases. Either hemorrhage or perforation may cause an acute collapse, the hemorrhage being in many cases internal. Sudden development of acute perforative peritonitis in an infant should lead one to think of duodenal ulcer. Spontaneous recovery occurs in a small number of cases. L. Emmett Holt (*Med. Record*, Aug. 20, 1913).

ETIOLOGY.—Sex and age are of significance in this connection. According to Krauss, duodenal ulcer is more common in men than in women, the ratio being 10 to 1; according to Robson and Wier, the ratio is 6 to 1; Mayo and Graham, $2\frac{1}{2}$ to 1; the Fenwicks, 4 to 1; Perry and Shaw, 3 to 1, or, if burns are excluded, 6 to 1.

Moynihan's cases reported up to the end of 1908, a total of 187, comprised 138 males and 49 females, or 73.7 per cent. and 26.2 per cent., respectively. The second group, re-

ported upon in 1909 and 1910, 115 in number, included 93 males, or 80.9 per cent., and 22 females, or 19.1 per cent. The ratio is practically 4 to 1 in each series.

As to age, duodenal ulcer may occur in any period of life, being most common, however, between the ages of 30 and 50 years. T. D. Lister reported a case of duodenal ulcer in a child 3 days old, and Spiegelberg, one in a child 5 days old. A number of other cases occurring within the first few days of life clinically characterized as cases of melena neonatorum have been reported. These have been shown to be due to infection, probably through the umbilicus.

Most gastroduodenal ulcers have a syphilitic etiology. The clinical histories of these cases are given and generally show that the ulceration yields to an antisyphilitic medication. A causal treatment is the only one capable of effecting a radical cure. M. R. Castex (*Prensa med. argent.*, iv, 194, 1917).

In this connection, moreover, it is interesting to note that duodenal ulcer formerly occurred in a goodly proportion of cases of extensive burn of the body surface—according to Fenwick, in 6.2 per cent. of fatal cases of burn. These cases were doubtless the result of infection, and they have become excessively rare under the modern aseptic and antiseptic methods of dressing such wounds. Attention should be paid to the tuberculous type,—rather the latent or concealed tuberculous cases than the active, in which both gastric and duodenal ulcers frequently occur. In all cases the actual lesion is probably the result of an embolus or thrombus, and, in the light of the study made by T. R. Elliott ("The Experimental For-

mation of Acute Gastric Ulcers," *Quart. Jour. of Med.*, vol. vii, No. 26, Jan., 1914), a direct toxic destruction of cellular areas cannot be ruled out. These foci, degenerative from any cause, are then acted upon by the gastric juice.

Case of sudden death by reason of a massive hemorrhage from a duodenal ulcer nearly four weeks after a traumatic extraperitoneal rupture of the bladder with extravasation of urine. The patient had seemed to be convalescing, notwithstanding the severe lesion of the bladder and adjacent region. Report of 16 other more or less analogous cases, with hemorrhage from alimentary tract after injury or operative work on urinary system. J. B. Roberts (*Trans. Amer. Surg. Assoc.*, 1908).

Duodenal ulcer found in 0.4 per cent. of 8538 necropsies. In 24 cases the ulcer was single and in 10 multiple; in 4 there was an associated gastric ulcer and in 2 hemorrhagic erosions in the stomach. In none was there a history of extensive burn, but in 8 the ulcer followed an operation in which the omentum or mesentery had been ligated. A thrombus had evidently formed, worked its way backward against the current, and injured the duodenal lining, where it finally lodged. Dietrich (*Munch. med. Woch.*, March 19, 1912).

The commonest type of gastric or duodenal ulcer, at least in material obtained by necropsy, is the arteriosclerotic ulcer in persons over 30 years of age (18 cases found among about 1500 necropsies). There is a second class of gastric or duodenal ulcer, in the young, probably due to local endarteritis (4 cases). Occasionally one observes acute embolic or thrombotic ulcers (1 case). W. Ophüls (*Archiv f. intern. Med.*, May, 1913).

In 10 out of 14 ulcers in infants examined by the writers, diplococci were found in great numbers in the ulcer base. Gerdine and Helmholtz

(*Amer. Jour. of Dis. of Children*, Dec., 1915).

The usual ulcer of the stomach and of the duodenum in man is primarily due to a localized hematogenous infection of the mucous membrane by streptococci. Rosenow (*Jour. of Infect. Dis.*, Sept., 1916).

PATHOLOGY.—In most instances the ulcer is above the site of the papilla in the duodenum. Duodenal ulcers are shelving and beveled in type, with their larger opening directed toward the mucosa, very rarely undermined. As a rule, the wall is thick and indurated, this, of course, depending upon the duration. Adhesions to surrounding structures are very common. Perforation may occur before adhesions to some structure or organ have been established. In that event general peritonitis follows. After adhesions are formed, a local abscess may occur, which may rupture; or, a fistulous tract may be formed, opening into the pancreas, gall-bladder, or liver. Cicatricial contraction following an ulcer may result in retention of food, with dilatation of the stomach, obstruction of the common or pancreatic duct, or even of the portal vein.

Mayo has drawn attention to an anemic spot sometimes visible on the anterior wall of the duodenum in the common site of the scar of a duodenal ulcer. The position of this spot corresponds to the center of the area supplied by the supraduodenal artery, and in these cases it is highly probable that this vessel, arising at a high level and running down to the duodenum, is put on the stretch and has its lumen narrowed or obliterated. D. P. D. Wilkie (*Surg., Gynec. and Obstet.*, Oct., 1911).

Fifty-two chronic duodenal ulcers excised with satisfactory results without performing gastroenterostomy. Ulcers in the anterior wall of

the duodenum, with obstruction and callus, upon excision often show a defect scarcely larger than a dimple. In the larger ulcers of the anterior wall the base is not often clean-cut and grayish white, like gastric ulcer, but more resembles a moth-eaten patch. Ulcers of the posterior duodenal wall present the same characteristics as those of the stomach, that is, a clean-cut, definitely punched out area, attached closely to the pancreas and usually completely perforating the duodenum. An anterior contact ulcer is usually found opposite the lesion on the posterior wall. Excision of duodenal ulcers should be limited to those occurring on the anterior wall. Wm. J. Mayo (*Annals of Surg.*, May, 1913).

Duodenal ulcers, by the extent and character of their cicatrization, often produce crippling distortions of the bowel. Thus, there are annular constrictions; circular ulcers; hour-glass duodenum, in which there is double constriction; "kissing" ulcers, so called because they lie on opposite sides of the bowel and when the organ is empty come into contact, and diverticula, or "pouching" ulcers. The author recently met with what he terms a "tubular" constricting ulcer of the duodenum. One-half inch beyond the pyloric vein, the duodenum for about $2\frac{1}{2}$ inches was constricted to about one-quarter its normal diameter. Its walls were indurated, and the condition was due to ulcer affecting the whole circumference of the bowel. A posterior gastroenterostomy was done, followed by uninterrupted recovery. Joseph Burke (*Buffalo Med. Jour.*, Feb., 1914).

PROGNOSIS.—Because of the greater frequency of duodenal than of gastric ulcer, and its frequent failure of recognition, at least until very recent years, the mortality has been higher than in the case of gastric ulcer. The condition is certainly an operative one in a larger proportion of cases than is the case with gastric

ulcer, and when it is recognized in time operative interference is fraught with little danger and results in complete recovery.

Two fatal cases of bleeding from duodenal ulcers in spite of the operation of gastroenterostomy. In both cases the ulcer was on the posterior surface of the first portion of the duodenum, and in both the fatal hemorrhage came on at a time when it looked as if the patients would recover from the operation. Thompson (*Annals of Surg.*, May, 1913).

TREATMENT.—In any case in which the symptoms have lasted for any length of time or, having been quiescent for a period, have then recurred, operative interference is absolutely essential. During the acute phases,—particularly in the cases with nervous symptoms, suffering from insomnia,—absolute **rest in bed**; careful **regulation of the bowels**; the use of **cream before meals**, about 2 to 4 ounces, with **Célestin Vichy** an hour or two after meals, and the administration of a soft **diet**—soups being, however, excluded—will frequently effect an apparent cure. If the frequency with which the long, narrow, acute-angled chest, with a prominent second rib, is to be found in these cases is borne in mind, the importance of attention to the general health will be at once apparent. (For the surgical treatment of duodenal ulcer, see Vol. I, p. 41.)

Patients with duodenal ulcer do well upon a **Lenhartz diet**. The author often combines with it $\frac{1}{2}$ ounce (15 c.c.) of **olive** or **almond oil** three times a day. On this plan $\frac{1}{2}$ ounce (15 c.c.) of oil is given every three hours and increased to 1 or 2 ounces (30 or 60 c.c.). Nothing else is given except water for thirst, until there is no blood in the stools. Cream is then given and the foods

of the Lenhart diet added gradually, but not the rice. The oil is then reduced to 1 ounce (30 c.c.) before each meal. He has tried this method thoroughly, and recommends it for patients who will endure it. If retching or vomiting is caused the treatment should be altered. If the patient does not respond to one or other form of dietetic treatment, the possibility of the symptoms being due to gallstones must be carefully reconsidered. Spriggs (Brit. Med. Jour., No. 2577, p. 1216, 1910).

In severe cases of gastric or duodenal ulcer with hemorrhage the author advises **absolute rest in bed** and a **liquid diet** for two or three days, until the vomiting ceases and there is no more hemorrhage either into the stomach or duodenum. The liquids should consist of orange juice without sugar, milk, and broth. Then gradually one should add eggs, meat balls underdone, fresh fruits, and green vegetables cooked, particularly those of the softer kind, like squash. After six to ten days every variety of meat, fish, green vegetables, and cooked and uncooked fruit can be given. Care must be taken to exclude in every form sugar, potatoes, bread, toast, cakes, and pastry. The only medication given is **dilute nitric acid** before meals from the onset of the attack, in doses of from 15 to 20 drops of the dilute preparation in half a tumbler of water. W. E. Deeks (N. Y. Med. Jour., Nov. 30, 1912).

Dividing the cases into 4 groups, the writer states that the results of treatment are now about as follows:—

Simple Duodenal Ulcer.—The usual symptoms are epigastric distress 2 or 3 hours after meals; sometimes hunger pains; long periods of euphoria alternating with comparatively short periods of suffering. Gastric hemorrhage or melena may have occurred once. This group gives a comparatively good prognosis, provided that some form of **rest cure** is rigidly carried out; **rectal alimentation**, then **von Leube-Ziemssen milk diet**; or duodenal alimentation; or simply a

milk and egg diet and rest abed for about 2 or 3 weeks. Later on, no overexertion (physical or mental) and a general hygienic way of living.

The oftener the attacks recur the more doubtful the prognosis by medical measures. **Operative intervention** (gastroenterostomy, preferably with pyloric occlusion) offers a pretty good prognosis.

Duodenal Ulcer Accompanied by Pylorospasm and Hypersecretion (alimentary or continuous)—Severe pains and frequent vomiting. Hypersecretion occurs constantly. When the pylorospasm reaches a higher degree slight isochymia occurs off and on.

The prognosis of this group is not very good under ordinary methods. **Duodenal alimentation** gives a better prognosis. In case it fails after from 2 to 3 weeks, an operation (**gastroenterostomy with pyloric occlusion**) should be performed.

Duodenal Ulcer Accompanied by Pyloric or Duodenal Stenosis.—Isochymia is here constantly present. In cases of beginning pyloric stenosis, duodenal alimentation and then stretching of the pylorus may be tried. The prognosis varies. Should there be no improvement, or in case the stenosis is further advanced, so that the duodenal bucket fails to pass, **gastroenterostomy** should be performed. Results are usually very good. In duodenal stenosis, when situated below the papilla of Vater, there is bile constantly found in the stomach or in the vomitus. The treatment requires surgical intervention and the prognosis then becomes pretty good.

Duodenal Ulcer with Periodically Recurring Hemorrhages.—The chief symptom is profuse hemorrhage (either hematemesis or melena or both), which returns periodically. An interval operation (**gastroenterostomy, eventually with pyloric occlusion**) gives the best results. Yet, hemorrhage may occur even after apparent recovery. Einhorn (Trans. Amer. Congress of Internal Med.; N. Y. Med. Jour., July 21, 1917).

In the acute cases of gastric and duodenal ulcer the author allows **no food by mouth for five to seven days**, sometimes longer. **Morphine** is given hypodermically until hemorrhage has positively ceased, an **ice pack** placed on the **abdomen**, and, if necessary, the bowels moved by an **enema**. In the absence of hemorrhage **hot applications** may be made, a **saline purgative** administered, and later 30-grain (2 Gm.) doses of **bismuth subnitrate** given, in conjunction with 7½-grain (0.5 Gm.) doses of magnesium hydrogen dioxide (25 per cent.), three times daily. Small quantities of boiled water may be required to insure retention of these drugs. For nutritive purposes the author institutes immediate **rectal feeding** with a solution of **dextrose**, which, he has observed, is absorbed almost *in toto*. One-half liter (1 pint) of a 10 per cent. solution of dextrose in normal saline solution is introduced into the rectum at body temperature every six hours, by means of a rectal feeding apparatus, applying the Murphy drop principle. The apparatus consists of an inverted vacuum bottle fitted with outlets, a soft-rubber dispensing tube, and, connected with a gauze glass, a drop chamber, together with devices for controlling the flow of solution. The latter is placed in the receptacle at boiling temperature and delivered at body temperature. By this plan the patient can be supplied with over 700 calories daily. As soon as the condition permits, oral feeding should be resumed, beginning with albumin water. Then well-cooked and strained oatmeal gruel or thick barley soup is given, and, finally, other thick soups and boiled, scraped meats are added to the **diet**. L. M. Gompertz (Monthly Cyclo. and Med. Bull., March, 1913).

Epinephrin given for gastric and pyloric spasm in duodenal ulcer in 4 out of 5 cases yielded favorable results. Another method of overcoming pyloric spasm is **duodenal alimentation** as advocated by Einhorn. C. G. Stockton (Med. Record, May 10, 1913).

Scarlet red employed in 37 cases of gastric and duodenal ulcer. It is a useful adjuvant. While it cannot replace the usual forms of treatment (Leube and Lenhartz), when administered in conjunction with them it often renders the cure more complete. As a help in ambulatory cases it is of great service, its effect being apparently even more favorable than that obtained from bismuth. Its use need not in any way interfere with the giving of other remedies, such as the **alkalies** or **belladonna**, when indicated. It is best administered in doses of 15 grains (1 Gm.), three or four times daily, before meals. It may, however, be given in much larger doses. No toxic effect was observed during its employment in over 100 patients. J. Friedenwald and J. F. Leitz (Monthly Cyclo. and Med. Bull., June, 1913).

If the pylorus is obstructed by the duodenal ulcer the results of **gastro-jejunosomy** are usually good, because the chyme must pass through the new stoma; but when the pylorus is patent the chyme flows through it and in some instances ignores the new route. The efflux can be watched with X-rays. It is better whenever practicable to **excise the pylorus with the ulcerated portion of the duodenum** and anastomose the stomach and duodenum. Sir John Bland-Sutton (Lancet, Feb. 9, 1918).

SIMPLE FOLLICULAR ULCERS.

These have already been considered under the chronic form of intestinal catarrh. As has been stated, the condition is usually secondary to the acute form; but it may occasionally arise without previous acute symptoms. It is the rule in portal congestion from any cause. When ulcers are present in any number, the enteritis is naturally of a more marked type, and masses of mucus occur in the stools. Pain may be absent, and

is rarely severe, the most striking features being the malnutrition, loss of weight, anemia, and mental depression. The affection is usually afebrile, and the treatment is that of chronic enteritis.

STERCORAL ULCERS.

These are merely a form of pressure necrosis, with perhaps a certain amount of toxemia, due to the presence of hard scybala, which may sometimes be converted into enteroliths by infiltration with lime salts. Chronic constipation is the most pronounced clinical feature usually, though rarely these masses may become tunneled, so to speak, and an apparent diarrhea supervene. When the masses are low down, digital exploration will reveal them. They are most common in old age, and usually occur in the cecum, sigmoid, or rectum. There may be slight tormina, and, when the affection is seated low down, tenesmus and a moderate amount of meteorism. When the stools become loose, they contain mucus, more or less pus, and occasionally blood. In very thin people, with lax abdominal walls, fecal masses may frequently be felt.

TREATMENT.—The treatment should consist at first of **enemas**, without the administration of laxative medicines by mouth. From 8 to 16 ounces of warm **olive oil** should be introduced into the bowel rather slowly and with very little pressure. This should be retained for some hours, then followed by 1 or 2 drams (4 to 8 c.c.) of **turpentine** emulsified with egg albumin, 1 ounce (30 c.c.) of **glycerin**, and 2 or 3 quarts (liters) of soapy water. On the following day, a **physiological saline enema**

should be used, and if there is much pain an enema consisting of a 1 or 2 per cent. solution of **quinine and urea hydrochloride** administered. This is both anesthetic and, to a degree, antiseptic. After a thorough evacuation has been effected in this manner, the treatment should be dietetic, with particular efforts to guard against further constipation.

ULCERATIVE COLITIS.

This condition may form part of the picture of a chronic intestinal catarrh, or may occur in the course of chronic Bright's disease, particularly toward the end, or as a result of the prolonged use of mercury. In the most marked case which I have ever seen it developed in an individual who had been giving inunctions of mercury to a tabetic over a long period, using his bare hands. On this case I conducted a post-mortem. Ulcerative colitis may also occur in scurvy, in severe purpuras, gout, and occasionally in leukemia, especially of the subacute lymphatic type. The ulcers may be disseminated or practically confluent, separated here and there by bridges of mucosa which have undergone polypoid growth. In all instances, in proportion to the duration of the condition, the wall of the bowel is thickened.

SYMPTOMS.—Often insidious in onset, the condition is characterized by alternating constipation and diarrhea, with pus and blood in the stools. When the disease is pronounced, emaciation becomes extreme, and irritability, marked mental depression, or even melancholia is superadded.

DIAGNOSIS.—The diagnostic use of a sigmoidoscope or proctoscope

should never be omitted in these cases. They often remain unrecognized until late in the course of the malady, when nutritional changes have become too pronounced to permit of recovery. Pus and occult blood or gross blood streaks in one with marked nutritional disturbance and diarrhea, or constipation alternating with diarrhea,—especially if pus be found in the stool,—should always be regarded with suspicion.

Examination of the abdomen in ulcerative colitis shows an absence of rigidity; there is tenderness in the course of the large intestine, oftenest at some one or more distinct points. The perineal mucous membranes are blanched. The grip of the sphincter is felt to be relaxed. To make more detailed examination the bowel must be cleared out thoroughly with soap and water enema, followed by irrigation at 105° F. The result in all probability will be the evacuation of a large quantity of decomposing fecal material. When the bowel has been well cleansed—and this takes from twenty-four to twenty-eight hours—an examination should be made and the sigmoidoscope then used. In the simpler forms of ulcerative colitis the mucous membrane will appear congested, blood will trickle down the open end of the sigmoidoscope, and when this has been swabbed away, eroded patches will become visible in the upper part of the rectum. In the more severe cases the mucous membrane will be found destroyed over large areas and the portions which remain appear in the form of "tags," which may become adherent one to another, forming little arches or bridges, which hang freely in the bowel. D'Arcy Power (Medico-Surg. Jour. of the Tropics, April, 1912).

PROGNOSIS.—The prognosis is always grave, and, of course, in the chronic Bright and leukemic cases

it is necessarily fatal. The same may be said of the chronic mercurial type.

TREATMENT.—If the case be seen sufficiently early and recognized, and the usual remedial measures prove of no avail, an **appendectomy** should be done and the colon subsequently washed out daily through the appendiceal opening, the method which gives such excellent results in mucous colitis. Before the more severe measures are undertaken, a 2 per cent. **quinine solution**, as noted above; a 2 per cent. **creolin solution**, a **silver-nitrate solution**,—from 5 to 30 grains (0.3 to 2 Gm.) to the pint (500 c.c.),—or a 1 per cent. **protargol solution**, given by enema, may be employed. As long as coarse residue from food, such as seeds, the skin of fruits, and cellulose material, is excluded from the **diet**, it is advisable to administer as much food as the patient is able to take, even in the form of solid diet, in order that the nutrition may be kept up. Mastication of food is a more normal physiological act than that entailed in the drinking of liquids, and as long as the small intestine is capable of digesting the food no irritation in the colon will follow the use of a larger dietary.

In the author's most successfully treated cases of ulcerative colitis he used an **emulsion of sulphur**, 120 grains (8 Gm.) in 4 ounces (120 c.c.) of oil. This was thrown into the colon through an artificial anus every other day, and on the alternate days thorough sluicing with **boric acid solution** carried out. This was done for seven weeks. With the idea of promoting adhesion to the mucosa, Shiga has employed **enemata of gum arabic** mixed with **subgallate of bismuth**, or **iodoform**. Hawkins (Brit. Med. Jour., May 27, 1909).

High rectal injections of boric acid found useful in ulcerative colitis. In one case the injection of a 1 per cent. aqueous solution of a **silver** synthetic at 80° F. completely stopped the diarrhea. A peculiarity of the case was that when about 5 pints had been introduced, the patient being in the knee and elbow position, the fluid was observed running out of the mouth and was identified not only by its physical characters, but by chemical tests. The author is not in favor of appendicostomy. A right-sided **colostomy** is in every way preferable and often gives immediate relief. W. Murrell (Med. Press and Cir., Sept. 20, 1911).

The symptoms of ulcerative colitis are about the same as in cancer of the colon, but direct visual inspection shows the numerous scattered small necrotic scabs, red granular mucosa, and subepithelial hemorrhages characteristic of the former; in cancer of the sigmoid flexure the mucosa generally appears pale. Local treatment is almost indispensable; **hydrogen dioxide**, **potassium permanganate**, **silver nitrate**, and **bismuth** are recommended, as also **starch enemas**, to be retained, and **hot gelatin enemas**. In the majority of cases the ulcerative colitis is restricted to the sigmoid, and this permits effectual direct treatment with 2 or 5 per cent. silver-nitrate solution or 5 or 10 per cent. **zinc chloride** after the parts have been thoroughly cleansed. Dry powders can also be applied, or a strip of gauze dipped in 0.25 per cent. silver-nitrate solution introduced and left until the next defecation. Kretschmer (Centralbl. f. d. Grenzgeb. d. Med. u. Chir., Sept. 8, 1913).

In the cases in which the author practised **appendicostomy** good results were obtained, but not always entire cures. In some cases injection of water into the cecum through the appendix causes considerable colicky pain and violent peristalsis. When the treatment is given every day a severe irritability is produced in the rectum,

The best irrigation of the sigmoid and rectum can be obtained through a right inguinal **colostomy**. In very severe forms of ulcerative sigmoiditis and proctitis this operation promptly cures. Its value is due largely to the physiological rest given the bowel. As a rule, temporary colostomy does not afford sufficient time to effect a cure. A permanent colostomy can be closed at any time the ulcers are found to be cured. J. A. Macmillan (Detroit Med. Jour., Dec., 1913).

The writer highly recommends **transduodenal lavage** in postoperative ileus. Its employment is of distinct advantage. It is well to recall that the solution is warmer than usually employed, from 110 to 120° F. (43.3° to 48.9° C.). The original solution Jutte advised was employed, namely 9 Gm. (2¼ drams) each of **sodium sulphate** and **sodium chloride**, 4 c.c. (1 dram) of a 10 per cent. alcohol solution of **phenolphthalein**, and a teaspoonful of **sodium bicarbonate** dissolved in a liter (quart) of water. Anthony Bassler (So. Med. Jour., Jan., 1919).

INTESTINAL TUBERCULOSIS.

ETIOLOGY.—Intestinal tuberculosis is said to occur both as a primary and as a secondary manifestation, though as a primary condition it is extremely rare. Further doubt is thrown upon its primary existence when one calls to mind the experimental work of G. S. Woodhead, who fed infected, tuberculous food to animals. The organism was found to pass through the intestinal wall, involve the peribronchial lymph-glands and lungs, in by far the greater proportion of instances without leaving evidence of intestinal involvement, and only in the minority did there result an involvement of the mesenteric lymph apparatus. Northrup also has called attention to this fact, from the clinical and post-mor-

tem standpoints, in the case of bottle-fed children. Occasionally, one meets with a case in an adult in which the symptoms are primarily those of appendicitis, but which subsequently develops intestinal tuberculosis, or, rarely, the peritoneum may be primarily infected. Intestinal tuberculosis occurs by far most commonly in children, especially in the bottle-fed.

Two cases of primary intestinal tuberculosis reported in one family. The older of the patients, 1 year of age, died after an illness of six days. The younger lingered for two months. There was no doubt that the tuberculous nurse infected both babies by prolonged personal contact. A post-mortem held on the younger child showed conclusively primary intestinal tuberculosis. Snow (*Arch. of Ped.*, April, 1907).

Intestinal tuberculous infection is very common in infancy, but the individual organism reacts to it in some with the production of immunity, while in others the reaction takes the form of the "scrofulous diathesis," which entails greater susceptibility to secondary infection later. Edens (*Berl. klin. Woch.*, Bd. xlv, Nu. 7, 1907).

In more than 60 per cent. of the cases of primary tuberculosis of the mesenteric glands the bovine type of bacillus is causative. In adults the majority of infections are caused by the human variety. In children, as well as in adults, bovine or human tuberculosis may become limited and healed, and the bacilli may die. Hess (*Amer. Jour. Med. Sci.*, Aug., 1908).

PATHOLOGY.—Intestinal tuberculosis is associated, as a rule, with more or less enlargement and caseation of the mesenteric lymph-glands, occasionally also with peritonitis. The mesenteric cases in children were at one time described as *tabes mesenterica*. Secondary intestinal

tuberculosis is very common, and is associated with pulmonary tuberculosis, the bowel lesions in most instances being in the lower end of the ileum, the cecum, and the first portion of the ascending colon. Not rarely isolated ulcers may occur in the rectum, and, indeed, this latter may constitute the only site of tuberculosis in the intestines, and give rise to fistula in ano.

The morbid change begins in the intestinal lymph apparatus or occasionally within the mucosa. Tubercles form, which become confluent, caseate, necrose, and form ulcers. Unlike typhoid ulcers, tuberculous ulcers present their long diameter at right angles to the long axis of the bowel. They are irregular, sinous in outline, with infiltrated edges and base, and upon the serous surface, especially near the attachment of the mesentery, and sometimes leading into the mesentery, minute tubercles may occasionally be seen. Frequently the submucosa and muscular layers are involved. There is very little, if any, tendency to healing. Perforation and peritonitis may occur, though less frequently than in the case of typhoid fever. Occasionally, fatal hemorrhage occurs. In very chronic cases cicatrization may be more or less complete, even resulting in the formation of strictures. In the chronic type the peritoneum over the ulcers is not seldom thickened.

The rarer form of chronic tuberculosis of the intestine is that in which the ileocecal region is involved. This form is characterized by marked hyperplasia and thickening, often involving the appendix in plastic exudation, without much caseation, and often without ulceration. These

changes are apt to result in the formation of a firm, tumor-like mass, which may be mistaken for a malignant growth. The parts are firmly bound by adhesions, and are more or less tender on pressure. Rarely in women tuberculosis of the tubes, and in children tuberculosis of the mesenteric glands, may result both in peritoneal and intestinal tuberculosis.

In 56 persons dead of pulmonary tuberculosis the author found the intestines diseased in all. In 30 cases there was diffuse tuberculous enteritis or catarrh. Among these were 4 with tuberculous mesenteric glands, 4 with tuberculous retroperitoneal glands, and in 6 simple enteritis, jejunitis, ileitis, or colitis, not showing tuberculous lesions. In 14 cases tuberculous ulcers of the ileum and colon were found. Of 12 cases with tuberculosis of the glands, in 6 the entire intestinal mucosa was intact. J. C. Hemmeter (Jour. Amer. Med. Assoc., Feb. 29, 1908).

SYMPTOMS.—Irregular fever and emaciation, with gastrointestinal disturbance, anorexia, and in some instances night-sweats, constitute the symptomatic picture of intestinal tuberculosis. In some instances the diarrhea is the most troublesome feature, and in these, very frequently, amyloid disease has resulted from the underlying tuberculous process.

In the hyperplastic, ileocecal form of intestinal tuberculosis the predominating symptoms simulate those of chronic recurrent appendicitis or chronic intestinal obstruction, consisting of more or less severe pain and, from time to time, diarrhea alternating with constipation.

The first symptoms of primary tuberculosis of the mesenteric glands are attacks of pain, the further development of the tumor, causing compression and various digestive dis-

turbances, constipation, vomiting, and diarrhea, with emaciation. Palpation reveals a movable, knobby, sensitive abdominal tumor, generally on the right side. This tumor can be separated from the other abdominal organs, and sometimes a pedicle leading downward into the depths can be recognized. Mächtle (Beiträge z. klin. Chir., July, 1908).

Tuberculous mesenteric glands are to be found in practically every child submitted to operation. There can be no mistake in assuming that the great mode of entrance of tuberculosis from the intestine to the body is by the lymphatics of the ileocecal region, and that, therefore, tuberculosis of the mesenteric glands originates from there. The children suffer from chronic ill health, and from abdominal pains referred to the umbilical region, coming on at night and sometimes after food. With anorexia there is often disturbed bowel action, generally constipation. There is always found in these cases a somewhat dilated appendix, containing fecal material, but otherwise not diseased. The author accordingly **removes the appendix** in these patients. Two or three weeks after operation the patient is sent away to a country home. In 9 cases out of 10 improvement is rapid and marked. Corner (Lancet, Feb. 17, 1912).

Case of primary mesenteric tuberculosis with the clinical picture of acute ileus in a boy of 16. In a second case the onset was equally sudden, and acute appendicitis seemed unmistakable. Both patients were apparently cured by prompt **excision** of the nodes involved. Schloessmann (Beiträge z. klin. Chir., April, 1912).

DIAGNOSIS.—The relatively prolonged course and the nutritional disturbance are the chief clinical evidences of tuberculosis of the intestines. When, in any case, the lungs become involved the diagnosis is, of course, clear.

In the diagnosis of hyperplastic tuberculosis of the cecum the chief difficulty lies between tuberculosis and cancer. Blood in the feces rarely occurs in tuberculosis of the cecum. The lymphatics of the mesentery become enlarged much more rapidly and more extensively than in carcinoma. Consideration must be given the duration of symptoms, the presence of other tuberculous scars or lesions, and to the family history and age of the patient. Nash (*Lancet*, Oct. 5, 1907).

In the diagnosis of tuberculous intestinal tumor the possibility of cecal cancer, dislocated kidney, fibrinous appendicitis, and scybalous accumulations must be considered. The generally younger age, slower progress, presence of pulmonary disease, tubercle bacilli in the stools, and the diazo reaction are among the principal points of difference from carcinoma. Dislocated kidney is more movable, gives a dull sound on percussion, and is not accompanied by stenosis. The distinction from fibrinous appendicitis can often not be made except by observation of the course of the disease. J. C. Hemmeter (*Jour. Amer. Med. Assoc.*, Feb. 29, 1908).

In 475 autopsies of chronic pulmonary tuberculous cases there were 13 instances, or 2.7 per cent., of intestinal perforation. Ten were complete perforations and 3 partial. The small gut was the site of perforation in 6, and the large one in 4. Acute peritonitis was present in 4 cases. Of the perforations in the large gut, 3 were in the appendix and 1 in the head of the cecum.

There can be advanced disease of the peritoneum in chronic tuberculosis without any marked symptoms or clinical signs. Only 4 of the author's cases of complete perforation had fairly typical symptoms and signs of perforation. Two had absolutely no abdominal symptoms, 1 had only pain in the abdomen, 1 had pain, tenderness, and rigidity, with some slight change in temperature and pulse, and another showed

only a drop in temperature. These symptoms occur not infrequently in cases without perforation. Thus, it is possible to diagnosticate complete perforation in only a limited number of cases, and never with certainty a partial perforation. J. M. Cruice (*Amer. Jour. Med. Sci.*, Nov., 1911).

Report of 1 case each of hemolytic jaundice and pernicious anemia in which the blood-picture was the main or only indication of latent intestinal and mesenteric lymph-node tuberculosis. Bretschneider (*Berl. klin. Woch.*, Dec. 11, 1911).

Unless tubercle bacilli are present in the stool in fair number, they are not diagnostic, as it is readily conceivable that with the ubiquitousness of the germ they may be swallowed from time to time. When they are found, however, with a greater or less number of pus cells and blood, and especially if they occur in association with a pulmonary lesion and are found in the sputum, the diagnosis is confirmed.

The prognosis is always grave, though rarely cicatrization may occur.

TREATMENT.—In the localized form, situated about the appendix, cecum, and ileum, operative interference may be practised with a fair measure of success.

Use of dilute **hydrochloric acid** in tuberculosis recommended to prevent the infection of the intestines. J. C. Hemmeter (*Jour. Amer. Med. Assoc.*, Feb. 29, 1908).

Two cases of extensive **excision** of the colon and ileum for tuberculous disease. The cecum, 4 inches of the colon, and 27 inches of the ileum were taken away in 1 case. The patient was well three years later. The second case, involving the cecum, descending colon, and hepatic flexure, was treated by a **lateral anastomosis** of the ileum to middle of transverse colon. Later on **resection** of the diseased parts was practised.

This case also recovered. Barker (Lancet, Sept. 23, 1911).

The treatment of Mandl with calcium salts is said to have been effectual. The writer's experience was equally favorable with it in 3 of 6 cases. It consists of the injection into a vein in the arm of a 5 per cent. solution of **calcium chloride**. With this simple measure the patients were freed of all the symptoms of their intestinal tuberculosis for quite a long period. Saxtorph (Ugeskrift f. Læger, Nov. 7, 1918).

INTESTINAL SAND.

This may be false or true sand. The former type consists especially of food residue, *e.g.*, seeds, fishbones, grain husks, and portions of the cores of pears or apples. Bananas are also said to give rise to this condition.

When, for any reason, phenyl salicylate (salol) is not properly broken up into its components in the first part of the intestine, it may pass through in the form of a sand. Olive oil occasionally forms little masses somewhat resembling gall-stones.

True intestinal sand, which occurs more frequently in women than in men, consists of a gritty material, largely composed of carbonate and phosphate of lime. These particles are of no clinical importance unless present in notable amount, when they act as mechanical irritants, producing colicky pain and mucous colic.

Case of a woman aged 48 with intestinal calculi, which she had been passing for a year. She had kept over 300 such stones. They were round, regular, grayish yellow, and calcareous. During this time she had taken 4 grains (0.26 Gm.) of sodium bicarbonate, calcined magnesia, and prepared chalk in cachets at each meal. Upon stopping these no more calculi appeared. Chemical examination showed them to be formed of carbonate of lime and

carbonate of magnesium, about half of each. Langenhagen (Jour. des praticiens, May 4, 1901).

The passage of intestinal sand or calculi may be attended by severe pain. The colic set up cannot, however, be explained by the narrowness of the canal. The site of the abdominal pain is very variable; most frequently it is more or less general. Distention is frequent, with or without eructations. The attack lasts several hours or a day. The frequency of the attacks is most variable in different cases.

In the treatment, in addition to relieving the pain by **opium** and **belladonna**, the stagnation and accumulation of sand and calculi should be overcome by **colonic irrigation**. The prophylactic treatment consists of a proper **diet** and **avoidance of constipation**. **Laxative waters** are indicated. Louis Vibert (Revue de thérap., June 15, 1901).

False intestinal sand is composed of remains of vegetable foods, perhaps a little incrustated with earthy salts. Pears, which often contain this sand before being eaten, are probably the most abundant source. True intestinal sand originates within the bowel. It occurs almost always with intestinal disorders, especially mucomembranous colitis. The characters of the organic bases and the large numbers of bacteria included point to the intestine as the most likely seat of origin. The richness of the material in urobilin and its poverty in unaltered bile pigment suggest that it is formed in a region where conversion of bile pigment is far advanced, namely, in the upper colon. It is not necessary to look to unabsorbed residues of the lime in food as the sole source of supply. Bunge has shown, however, that the actual amount of lime in milk is greater than in an equal volume of lime-water, so that this food may perfectly well be the source of lime in concretions. D. Duckworth and A. E. Garrod (Lancet, March 8, 1902).

Case of **true intestinal sand**. The chemical analysis showed: Moisture, 5.2 per cent.; calcium phosphate, 28.68 per cent.; calcium carbonate, 5.2 per cent.; magnesium phosphate, 0.49 per cent.; organic matter, 60.43 per cent. At the time the sand was passed the patient, a lady aged 44 years, had been on a milk and farinaceous diet for months on account of gouty diathesis. The gouty diathesis might bear an etiological relation to the production of the sand. Bedford (Brit. Med. Jour., Dec. 6, 1902).

A man suddenly developed symptoms of ileus, and after extensive bowel irrigation passed 50 cherry-stones. Ten or eleven months had passed since he had eaten the cherries. Case of a young physician who had used for ten years a mouth-wash of tincture of myrrh and krameria to relieve painful gingivitis. Particles of resin in the mouth wash collected in the digestive tract and caused symptoms suggesting recurring appendicitis, when, in fact, the trouble was merely irritation of the mucosa from the rubbing of the conglomerations of resin. These accumulated at the sigmoid flexure and sometimes caused slight fever, but the symptoms were always comparatively mild. The disturbances were cured by **dieting to insure soft stools** with as little development of gas as possible. The case had been puzzling until the discovery of resin lumps in the stools. B. Naunyn (Deut. Archiv f. klin. Med., Bd. lxxxiv, Nu. 1-4, 1905).

INTESTINAL CALCULI.

These are rare, occasionally of biliary or, still more rarely, of pancreatic origin. True enteroliths may result from the impregnation of fecal matter with lime salts.

INTESTINAL OBSTRUCTION.

DEFINITION.—Any part of the intestines may be obstructed completely or only in part, and the proc-

ess may be acute, subacute, or chronic. The term *ileus* is sometimes rather loosely employed to cover all of these forms, especially that condition commonly termed paralytic ileus, which is essentially intestinal paresis following abdominal operations. The word literally means, to roll, and it should be applied solely to inflammatory or spasmodic volvulus. The following terms are variously employed, according to the condition present: *Occlusion*, signifying complete obstruction of the lumen of the bowel; *stenosis*, considerable narrowing of the lumen or incomplete occlusion, so to speak, from any cause; *constriction*, narrowing due to extramural compression or traction; *stricture*, narrowing due to a cicatricial ulcer, gumma, or malignant growth; *obturation*, the presence of some intramural obstruction, *i.e.*, some factor operative within the lumen, as a foreign body, gall-stone, enterolith, or impacted fecal matter; *strangulation*, signifying not alone occlusion, but interference with blood and nerve supply, leading to gangrene; *incarceration*, which should not be confused with strangulation, and implies the imprisonment of more or less extensive coils of the intestine in pouches or cavities, usually scrotal or retro-peritoneal. One interesting form of incomplete obstruction, *i.e.*, constriction, is Littré's hernia, in which only part of the lumen of the bowel or a diverticulum is caught in a fold or pouch.

SYMPTOMS.—Acute Obstruction.

—This may result from strangulation, intussusception, volvulus, peritonitis, and foreign bodies, or it may be postoperative. It is rapid or sudden in onset, constipation, abdominal pain, and vomiting, with or without nausea, constituting the chief phe-

nomena. There is gradual development of gaseous distention only when the obstruction is low down, and occasionally a palpable mass. Pain is frequently the first symptom, often coming on suddenly; it is at first intermittent, colicky, and later more or less continuous and severe. When the lesion is low down, peristalsis may be visible above the obstruction. Nausea and vomiting soon follow, and hiccough is not uncommon. First, food contents are vomited, then a thin mucus, and later bile-stained material, while in occlusion the vomiting becomes distinctly stercoraceous. Early, an apparent movement of the bowels may occur as a result of peristalsis below the site of obstruction, but absolute constipation is the rule, neither gas nor fecal material escaping, though tenesmus may cause the passing of some mucus. Obstruction high up causes very little tympany. Obstruction of the large bowel may result in considerable distention. As a rule, more or less tenderness on pressure exists, sometimes exquisite, so that it is often impossible to feel a mass even when present. Rectal or vaginal examination may furnish some information.

Among the symptoms of intussusception of the sigmoid are: A feeling of unfinished stool, following a movement of the bowels; aching pain in the sacrum; a passage of mucus or membrane; a dragging sensation in the left iliac region, with a feeling of heat across the lower portion of the abdomen and back; periodical attacks of hemorrhage from the bowels; colicky pains before the bowels move; pain on sitting or standing for any length of time; headache, vertigo, nausea, vomiting, frequent and painful urination, and

pain down the back of the legs. The symptoms vary with the degree of intussusception, the length of time it has existed, and the involvement of other organs. The operative treatment consists essentially in suspending the intestine by passing 3 or 4 Pagenstecher sutures through the inverted transversalis fascia. Lynch (*N. Y. Med. Jour.*, June 6, 1908).

Report of 100 cases of intussusception. Polypus or some form of intestinal tumor was an important factor. The types were: Enterocolic, 73; colic, 16; enteric, 10; not noted, 1. Symptoms: Pain in 92 per cent. Vomiting, 90 per cent.; blood in 92 cases under 10 years of age; constipation in 33; diarrhea in 13; distention in 22 per cent. In 27 cases a tumor was felt in the rectum. Ninety-one cases were operated upon, with a mortality of 35.1 per cent. The cause of death was shock. J. E. Adams (*Pract.; Amer. Jour. of Gastro-Enterology*, June, 1911).

Symptomatology of acute intussusception in infants described as follows: Severe and sudden abdominal pain, coming on in acute attacks with intervals often of complete relief. The child may vomit, but never to any great extent. Tenesmus is marked, but with passage only of a little blood and slime. At first a motion or two may be passed, but after this there is absolute obstruction, and no trace of bile will be found on the napkin. This sign, first pointed out by Barnard, is almost infallible. The abdomen is fairly lax, unless the child is actively straining. A tumor may be felt in the region of the transverse or descending colon. It gradually shifts its position, advancing along the colon and increasing in extent. It is sausage-shaped and of horseshoe form, the concavity being toward the center of the abdomen. Manipulation causes it to contract and become hard, producing an attack of pain and an increase in the tenesmus. The characteristic feature is that,

although the tumor may not be very tender, and manipulation may cause no instant pain, the pain rapidly follows and continues long after manipulation has ceased. The apex may be felt by the rectum. H. S. Souttar (Brit. Med. Jour., May 10, 1913).

The patient soon shows evidences of profound illness. Anxious expression, pallor, cold sweat, sunken eyes, rapid heart, feeble pulse,—in short, collapse. The temperature is often subnormal, though it may be raised when peritonitis occurs,—not always, however. There is marked dryness of the mouth with constant thirst. When the lesion is high up, the urine is greatly diminished or even totally suppressed, while in lesions low down the urine is more or less scanty, dark, and apt to contain a quantity of indican. A leucocytosis, often of from 50 to 80 thousand, is not uncommon. Death usually occurs within a week, unless operative interference is practised.

Chronic Obstruction.—This condition, following the development of new growths, strictures, or fecal impaction, may extend over considerable periods of time, though, finally, urgent symptoms may suddenly develop, the case becoming acute. As a general rule, however, the chronic type varies somewhat, according to the underlying cause. In fecal impaction there is usually a history of chronic constipation, and, as has previously been noted, this may be masked as a result of tunneling of the intestinal contents, an apparent diarrhea resulting. This is especially the case in old people. More or less abdominal pain and distention, sometimes the passage of mucus, together with the history, and, in thin individuals, palpable masses in the abdomen,

constitute the clinical picture. Colitis, stercoral ulcers, even hemorrhage or perforation, may result.

In stricture, whether benign or malignant, the history is one of moderately long standing and gradually increasing constipation. Peristalsis is apt to be very active above the site of the obstruction. Pain is usually less severe, often absent; meteorism intermittent, unless the obstruction becomes complete, and vomiting is only occasional and may not occur at all, and is never fecal, except in late, complete obstruction. The general health suffers, doubtless in part owing to autointoxication, with anemia and loss of flesh, and death occurs from asthenia or acute obstruction. The stethoscope is not employed sufficiently in the diagnosis of abdominal conditions, as in peritonitis, or even in appendicitis with local peritonitis, in postoperative distention, and frequently in all forms of obstruction no intestinal sounds can be heard.

DIAGNOSIS.—In this connection there are to be considered both the site and nature of the obstruction and its recognition from other conditions which may simulate it. As to the site of obstruction, it is not always possible to determine this absolutely,—indeed, rather more frequently it is impossible,—but the age of the patient, and to a less extent the sex, are factors of considerable aid. For instance, volvulus, malignancy, and chronic constipation are to be looked for in the aged; intussusception, a constricting appendix, or Meckel's diverticulum in a child, and either of the latter two in youth or early manhood. The history is of importance as to whether operation has previously

been undergone, or an attack of peritonitis experienced, or whether previous ulceration of the bowel has probably existed as the result of some old infection. Digital rectal examination and inspection of the abdomen, and in women even a vaginal examination, may furnish collateral evidence. Either in the nature of a mass; or in the case of an obstruction high up, in the feeling of the empty coils of intestine which fall into the pelvis. Inspection of the abdomen is of value in noting the distribution of peristalsis and of tympany; the higher the obstruction, the less the tympany, and the converse is likewise true. Again, in obstruction high up, diminution of the urine or anuria, and the absence of indicanuria, are in striking contrast with the large amount of indican occurring in a more or less scanty urine when the obstruction is low down.

Even before any other signs indicate obstruction of the bowels, the stomach tube will aspirate fecally smelling stomach content. The author washes out the stomach on the slightest suspicion of ileus, and comments on the promptness with which the stomach fills up again with fecal matter after it has been evacuated. The violence of the general symptoms abates after the stomach has been thus emptied, and the patient comes to operation in much better condition. Ewald (Berl. klin. Woch., Nov. 4, 1907).

Persistent abdominal pain of severe type, with abrupt onset, in a patient in previous good health, unrelieved by rest and starvation, is the most notable sign and often the only one upon which a diagnosis of acute obstruction may be founded. In a majority of cases the fate of the affected gut is determined, and immediate operation demanded, within twenty-four or forty-eight hours.

One should, therefore, not wait long for the development of a complete clinical picture. E. W. Hey Groves (Bristol Med.-Chir. Jour., March, 1912).

It is well to remember that not all the symptoms of intestinal obstruction may be present. This is practically true of vomiting, and especially of the type which is usually considered pathognomonic, viz., stercoraceous vomiting. It is a serious mistake, in the presence of other strongly suggestive symptoms of obstruction, to wait for vomiting, or the distinctive stercoraceous vomiting, to confirm the diagnosis. The "mapped-out" variety of distention in many cases does not exist; especially in late cases, it may be entirely masked by general distention. F. D. Gray (Med. Times, Sept., 1912).

When the ileum and cecum are obstructed, distention is noted, especially in the central portion of the abdomen. Early fecal vomiting is then the rule. When the colon is involved, tenesmus frequently occurs, with passage of mucus and blood, and this is especially noteworthy too in intussusception, which occurs more frequently in children than adults. The course of the condition is somewhat slower when the colon is obstructed than when the small bowel is involved. Very little help may be expected from inflation with gas, and, as a rule, not a great deal from an attempt to determine the amount of fluid which the colon will hold. In volvulus this might be of some value. Better still, however, would be the introduction of a bismuth mixture by rectum, followed by an X-ray examination. Auscultation during inflation may occasionally aid in locating the site. In adults the capacity of the large bowel is from 5 to 6 quarts, but great care should be ex-

ercised not to use too much pressure, lest an already damaged bowel be ruptured.

Metallic sounds made by the bursting bubbles and falling drops in the intestines can be detected by auscultation very early in case of obstruction—much earlier than gurgling sounds, which are not heard until long stretches of the bowel are involved. M. Wilms (*Münch. med. Woch.*, Feb. 1, 1910).

According to the writer the intoxication in intestinal obstruction is due to a primary proteose, which, upon injection into animals, reproduces the symptoms. In peritonitis and acute pancreatitis the same proteose causes the toxic symptoms. H. Whipple (*Jour. Amer. Med. Assoc.*, July 1, 1916).

Among the most difficult obstructions to recognize are those in the nature of constrictions or strangulations resulting from Littré's hernia; likewise, constrictions in the foramen of Winslow or retroperitoneal hernias.

The nature of the obstruction oftentimes escapes recognition. Since the majority of cases of occlusion are due to strangulation, especially in males, age and sex in this connection may again furnish collateral evidence. Tumefaction is very rare in this type. An examination of all possible sites for the development of hernia should be made and the history as to mode of onset, presence or absence of anemia, emaciation or cachexia, previous gall-stone colic, or constipation obtained. In children tumefaction, tenesmus, and bloody, mucous stools favor intussusception, and in old age the greater possibility of volvulus may aid in detecting the nature of the trouble. Fecal obstruction is, as a rule, among the easiest of conditions to recognize.

As to differential diagnosis, the following conditions may be considered: Acute appendicitis or pancreatitis, peritonitis, and rarely a very acute enteritis with relaxation of the intestinal walls, abdominal pain, and vomiting. The presence or absence of fever, however, should determine the probability of disease of the appendix, and usually of the peritoneum, with local or general pain on pressure. In acute hemorrhagic pancreatitis it may be possible to elicit a history of typhoid fever, of previous gall-stone colic, or of marked gastric hyperacidity with acid eructations, pronounced irritability, and epigastric pain. Embolism of the mesenteric arteries, or thrombosis of the mesenteric veins, may also simulate obstruction from other causes. Gall-stone or renal colic, or torsion of the pedicle of a tumor or of a movable kidney of the third degree, may likewise interpose difficulties.

In uremic pseudoileus the patient's digestive apparatus has been out of order for some time, with alternating diarrhea and constipation, until the obstipation becomes unconquerable. The abdomen is not so distended as in true ileus; there is no colic and no appearance of peristalsis. If vomiting occurs, it retains its uremic character without fecaloid admixture and is independent of ingestion of food or contraction of the bowels. Edema or albuminuria confirms the diagnosis. Delbet (*Presse méd.*, Aug. 24, 1907).

Case of intussusception in an infant of three months in which the diagnosis was aided by the use of the X-rays. The patient was rayed after having had a bismuth emulsion injected into the rectum. I. M. Snow and M. Clinton (*Amer. Jour. Dis. of Children*, Aug., 1913).

Time lost in waiting for a sausage-shaped tumor to be palpable or for intussuscepted gut to appear in the

rectum in an infant may be sufficient to cost the life of the little patient. With the small gut distended palpation of the cecum may be impossible, or there may be an intussusception so small that no mass is palpable, or the whole mass may be hidden behind the ribs in the splenic flexure of the colon. In the case seen early, when treatment is most efficacious, the mass in the rectum is rarely met with. With a history of sudden onset of screaming, intractable vomiting, evidence of continuous pain, and blood and mucus in the stool, with an absence of fecal matter in the stool, a diagnosis of intussusception, particularly in infants under a year, may be safely made. There need be no great prostration at first, and this is the ideal time for operation. The X-rays are available for diagnosis in the doubtful cases, and should not be neglected. L. Miller Kahn (Med. Rec., Sept. 20, 1913).

In any case it may be deemed advisable to administer a general anesthetic, or, better, spinal anesthetic, which may greatly facilitate diagnosis. The use of spinal anesthesia in the postoperative cases, with paresis of the wall of the bowel, not only aids in the diagnosis, but at once puts a stop to the condition.

ETIOLOGY.—Intestinal obstruction may be due to (a) extramural; (b) mural, or (c) intramural factors.

Strangulation.—This is the most common of the extramural causes of acute obstruction. It may be due to adhesions, postoperative or acquired through previous peritonitis or preceding inflammation of an organ, with subsequent formations of adhesions; mesenteric and omental slits; pedicles of tumors; remnants of fetal structures, such as Meckel's diverticulum or fibrous remnants of fetal vessels (vitelline); an adherent appendix, which may form a loop or may sur-

round the ileum or cecum, usually the former; openings or pouches in the peritoneum, or inflammatory traction upon an intestinal loop, causing kinking; internal hernias through the foramen of Winslow; duodenojejunal, subcecal, intrasigmoid, diaphragmatic or Littre's hernia, or external pressure due to abscess formation, especially about the appendix or within the pelvis; cyst of the pancreas; hydronephrosis; abdominal or pelvic tumors, as of the ovary, uterus, kidney, or omentum. Kinks due to traction usually occur in the last part of the ileum, at the sigmoid, or the last part of the duodenum.

In cases of ptosis this latter is apt to occur, when it is spoken of as gastromesenteric ileus, the last portion of the duodenum being compressed by the root of the mesentery and its vessels. Acute dilatation of the stomach may arise in consequence. The kink of the ileum not infrequently associated with the mobile cecum, the condition to which the term Lane's kink has been applied, usually develops in the proximity of the cecum, where the mesentery is short. The mobile cecum falling over the brim of the pelvis may result in more or less definite obstructive symptoms, or may give rise to symptoms suggestive of an acute appendicitis.

According to Fitz, obstruction due to strangulation occurs in males in 70 per cent. of all cases, and in 40 per cent. of all cases between the fifteenth and thirtieth years. In 90 per cent. the small intestine is involved, considerably over two-thirds of these occurring in the right iliac fossa and four-fifths in the lower abdominal half.

Intussusception.—Of the mural forms, intussusception is most common in children, more than one-half of the cases before the tenth year, and many even before the termination of the first year of life. A very common cause of acute obstruction, much more frequent in males than females.

Records of a large English hospital, of 115 cases, show 10 per cent. in adults.

Inversion of the appendix; prolonged crying and straining are two of the principal causes of intussusception in infants. Trauma is a frequent factor in causing intussusception in adults, such as certain acrobatic feats, lifting of heavy weights, wrestling, and football. Elliot and Corcadea (Liverpool Medico-Chir. Jour.; Amer. Jour. of Gastroenterol., June, 1911).

In this condition infolding of the bowel occurs, the invagination being always a descending process (*post mortem* the reverse is often found, non-inflammatory, agonal). The upper portion of the bowel is swallowed by the lower, as it were, in consequence of which a tumor of cylindrical shape results, varying within wide limits from a fraction of an inch to one or more feet.

Intussusception is essentially a disease of childhood. The diagnosis can frequently be made from the mother's story. The sudden onset of symptoms, vomiting, pallor and sudden acute pain in the abdomen, and usually in the first 12 hours the appearance of blood in the stools will differentiate this lesion from colitis, the only condition to be ruled out.

X-ray pictures may be used to show the intussusception. The tumor felt by rectum is very often a late finding. G. Torrance (N. Y. Med. Jour., cvi, 400, 1917).

An intussusception is formed of three layers: the intussusciptiens, or

outer receiving layer, which, folding back upon itself, constitutes a middle or returning layer, and this, again, turning upon itself, forms the innermost or entering layer, or intussusceptum. A preceding diarrhea, a polypus or lipoma, or other benign pedunculated growths are the usual factors inviting this condition.

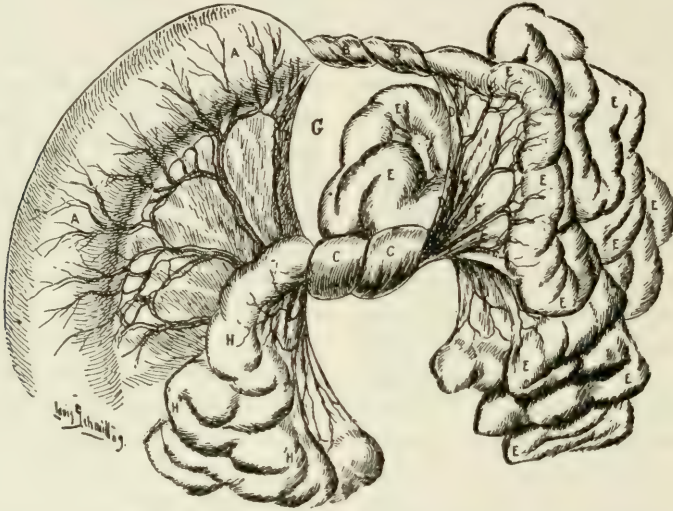
According to Fitz, intussusception constitutes 31 per cent. of the acute cases of obstruction. Several varieties exist, which from above downward are styled the ileal, in which the ileum alone is involved; ileocecal, in which the ileocecal valve descends into the colon and may be so extensive as to be felt per rectum. This last comprises about three-fourths of all the cases. Ileocolic, in which the terminal portion of the ileum passes through the ileocecal valve, into the cecum or beyond into the ascending colon. *Ileocecal*, rarely an appendiceal form, has been described in which the vermiform appendix has entered the cecum. *Colic* form, confined solely to the colon, and finally *colicorectal*, in which case the colon descends into the rectum.

In consequence of the invagination, the mesenteric vessels are compressed, especially those distributed to the middle and outer layers, so that oozing of blood or even considerable hemorrhage, with mucous stools, constitute an important clinical feature. The invaginated portion may slough, and in rare instances, when the middle and outer layers have previously become adherent, spontaneous cure has resulted, and occasionally the slough is discharged per rectum, as in a case of typhoid which came under my notice in which about 2 inches of bowel were passed by

rectum, with subsequent cure of the patient, without operative interference. It is rather surprising that intussusception does not occur more frequently in typhoid, because active irregular peristalsis is the essential predisposing factor.

The involved area is always more or less thickened and swollen, and later becomes pultaceous and gangrenous. Early, it may be readily re-

against the handle of a washtub. She suffered from no great shock and was able to continue her work on the following day. About a month later she developed symptoms of indigestion, which became progressively worse until, ultimately, the taking of food was followed immediately by pain and frequent vomiting. In 1906 the vomitus presented a coffee-ground appearance on several occasions. At varying periods the patient vomited food



A, dilated loop of jejunum; B, twists in jejunum, causing obstruction; C, twists in upper ileum; D, edges of mesenteric rent; E, eight-foot length of small intestine, which, rotating about its own mesentery F, has passed through the mesenteric rent G three times; H, ileum distal to the lesion.

duced, but when adhesions have formed it becomes fixed, and about the involved area more or less lymph is thrown out.

Volvulus.—Volvulus and twists or kinks in the intestine not due to adhesions and traction are essentially of the mural type, though perhaps a little less definitely than those cases resulting from a growth in the wall or structure following ulceration.

Case of intestinal obstruction due to a traumatic rent in the mesentery. In May, 1904, the patient, a woman aged 45, fell and struck her abdomen

which had been ingested twenty-four or thirty-six hours previously. On March 7, 1907, total obstruction supervened. The abdomen was opened and a piece of gut 8 feet long was found to have passed three times through a rent in the mesentery and so produced twists of the gut in two places. The coils of gut were returned through the rent, the twists were reduced, and the rent in the mesentery stitched up. The patient made an uneventful recovery. J. B. Carnett (Univ. of Penna. Med. Bull., vol. xxii, No. 5, 1909).

Volvulus, which is responsible for about 15 per cent. of the acute cases

of intestinal obstruction, occurs twice as often in males as in females, and especially about the fourth decade, though it may occur even later. In fully one-half of the cases it is situated at the sigmoid, next in the region of the cecum or some portion of the small intestine. In this condition a loop of bowel is simply twisted on its long axis or one loop may be twisted about a loop developed from another neighboring coil.

Volvulus of the sigmoid flexure in children. Two were in lads of 10 and one in a girl of 4. The condition is very rare in children under 15, but is so frequent after 20 that Treves is cited to the effect that 2000 persons die annually from this cause in England alone. W. E. Tschernow (Jahrb. f. Kinderheilk., Bd. lxiii, Nu. 3, 1906).

Case of volvulus of the ascending colon met with in a man 54 years of age, and operated on successfully six hours after the attack. The ascending colon was found to be sharply bent about three fingers' breadth below the hepatic flexure, the twisted portion lying with its longitudinal axis directed to the left. Replacement was not difficult, and the appearance of the intestine soon began to improve. Seefisch (Med. Klinik, Oct. 3, 1909).

It is generally considered that volvulus of the sigmoid flexure is the most common, while other parts of the intestinal tract are very rarely involved. The writer's observations lead to a different conclusion. Of 96 cases of acute intestinal obstruction, there were 8 of invagination, 8 of tumor (cancer, tuberculosis), 5 of properitoneal hernia, 20 of strangulated hernia, 8 of unknown cause, and 47 of intestinal volvulus. Of the 47 cases of volvulus, 18 were of the sigmoid flexure, 1 of the cecum, and 28 of the small intestine. Spasokozky (Archiv f. klin. Chir., Bd. xcix, S. 211, 1910).

Tumors.—These are more likely to give rise to chronic types, though the termination may be perhaps acute. Tumors growing from the wall of the bowel may be benign or malignant. Rarely pediculated benign tumors have become separated and have later passed *per rectum*. In the majority of instances malignant tumors are epitheliomas (cylindrical carcinoma), usually annular, occasionally circumscribed. The rectum, or one of the flexures, particularly the hepatic or the sigmoid, is the most common site. It is, therefore, more common in late adult life, more often in males, though recently a case of carcinoma of the sigmoid in a man of 30 came under my observation. Sarcoma is much less common, more apt to occur in children, usually of the small lymphoid cell type, and especially apt to involve the small intestine.

Strictures.—These may be congenital or acquired. The former are very rare and comprise cases of imperfect anus or congenital defect in the terminal portion of the bowel, or failure of union between the pylorus and duodenum. Acquired strictures are those resulting from previous ulceration, dysenteric, typhoid, tuberculous, syphilitic, or, indeed, any cicatricial ulcer.

Coprostasis; Gall-stones; Enteroliths; Foreign Bodies.—Obstruction due to intramural causes are perhaps most commonly fecal impaction (coprostasis), and, while this is most apt to be chronic, it sometimes develops acutely. The acute obstruction is most frequent in the sigmoid or cecum, usually in the aged, debilitated or melancholic, or actually insane individuals. Gall-stones which

have ulcerated through into the intestine usually obstruct at the ileocecal region or at the duodenum. Obstruction is very rare if ulceration takes place into the colon. Enteroliths due to the impregnation of fecal matter by magnesium and calcium oxalate or phosphate, or depositions upon gall-stones or other foreign bodies, or foreign bodies consisting of stones of fruit, buttons, coins, or round worms, may obstruct the bowel, or magnesia or bismuth taken medicinally may accumulate and cause obstruction.

In 21 cases of gall-stone ileus which the writer operated, typical colics had occurred in 6 cases and vague suspicious symptoms in 5 others—thus, only in 50 per cent. of the total. In 3 cases and in 1 reported by Lund the ileus was the first sign of trouble. In a few cases blood in vomit or stools with vague symptoms in the stomach region were ascribed to ulcer or cancer, but in reality they were the signs of a fistula developing between a bile-duct and the bowel. The ileus developed in 1 case immediately after a sudden physical strain and in another after a course of oil. Moller (*Hospitalstidende*, April 9, 1913).

Intestinal obstruction may occur when gall-stones having a greater diameter than 2 cm. enter the small bowel. Gall-stones of sufficient size to produce intestinal obstruction are, as a rule, too large to pass through the biliary ducts without some ulcerative or perforative process. W. W. Babcock (*N. Y. Med. Jour.*, June 7, 1913).

Two tumors with a tender zone between, all in the descending colon, proved to be an accumulation of 712 cherry stones. No cherries had been eaten for several months, and microscopic examination at necropsy revealed incipient malignant disease. The latter had probably interfered with normal peristalsis. A. Kotzareff

(*Revue Méd. de la Suisse Rom.*, Oct., 1918).

Intestinal paresis, postoperative obstruction, or paralytic ileus, so-called, can scarcely be grouped under any of the above headings, though it is essentially a condition resulting from more or less widespread paralysis of the muscular walls of the bowel, so that no peristaltic action can occur, and an obstruction, therefore, results. This is seen in those desperate cases of embolism or thrombosis of the mesenteric vessels previously described under the head of intestinal infarcts. It may occur, too, after injuries, especially blows upon the abdomen, following operations, chiefly abdominal.

It has been shown by Bayliss and Starling that the duodenal mucous membrane produces a "secretion" which when injected intravenously stimulates the pancreatic secretion, while adrenalin besides its various other actions also officiates as a hormone in the metabolism of the sugars. It would appear, therefore, that apart from their regular secretory activity many organs generate substances which are carried by way of the circulation to distant parts and there officiate as functional stimulants.

One of the most interesting discoveries is that of Zuelzer, Dohrn, and Marxer that the mucous membrane of the stomach contains a hormone, which when injected intravenously was found to stimulate intestinal peristalsis. It was later demonstrated that the same hormone can be extracted from the spleen in amounts sufficient to enable it to be utilized therapeutically. (*Intern. Jour. Surg.*, April, 1911.)

Very rarely intestinal paresis after tapping for the removal of abdominal fluid, occasionally in pleurisy, somewhat more frequently in pneumonia,

and rarely in cases of cardiac decompensation, particularly in those in which the liver has become very large. Rather rapid distention of the abdomen occurs, due to cessation of peristalsis, with the advent of obstructive symptoms. Hysterical patients may likewise manifest pseudo-obstructive symptoms.

Postoperative obstruction due to Trendelenburg posture is often due to torsion of the bowel from faulty position, owing to the free motion left to the bowel after reduction of intra-abdominal pressure. The elevated pelvis has the same effect in reducing pressure, and the bowels do not return to their normal place when the body is put in a horizontal position. Surgeons should, therefore, be very careful to bring the body back into this position and to see that the intestines are in proper position before closing the abdomen. David (*Tribune méd.*, No. 36, 1906).

Postoperative ileus is by no means a rare condition. The proportion of cases following laparotomies of all kinds ranges anywhere from $\frac{1}{10}$ of 1 per cent. to 2 per cent. The distinctive diagnosis between the pseudo-post-operative ileus and the true mechanical ileus in the early stages is exceptionally difficult. Prognosis in true mechanical ileus is far better than adynamic ileus. In the absence of infection the prognosis is generally good. Martin (*Jour. Amer. Med. Assoc.*, Sept. 21, 1907).

No more frequent and fatal complication of acute appendicitis exists than that comprising the various types of postoperative intestinal stasis. These may be assigned roughly to two main groups: First, those due to failure of peristalsis, resulting in intestinal paresis, distention, and stasis of the fecal current, and second, those due to mechanical obstruction resulting usually from kinks, twists, adhesions, or bands. The most familiar examples of the first group are the cases of paralysis

associated with peritonitis, causing a toxemia, acting either after absorption or locally on the neuromuscular mechanism of the intestine; the paralysis due to trauma, seen in the course of long abdominal operations involving manipulation and exposure, and that due to mesenteric thrombosis. Cheever (*Boston Med. and Surg. Jour.*, May 15, 1913).

The following are the etiological factors for postoperative ileus: (1) mechanical irritation of the peritoneum and intestine during operation; (2) infections of the peritoneum; (3) adhesions of the intestinal loop to abraded surfaces or to adhesion strands; (4) closure of mesenteric vessels. The postoperative distention which is nearly always present is likely to be a signal of danger. A strict prophylaxis includes pre-operative care. E. W. Pinkham (*Amer. Jour. of Obstet.*, lxxvii, 614, 1918).

PATHOLOGY.—There are three types of intestinal obstruction: First, and most frequent, the acute variety. Second, chronic intestinal obstruction. Third, acute obstruction engrafted upon a chronic. In the acute type, in which the lumen is suddenly and completely blocked, in the majority of instances, there is an associated strangulation, with consequent interference with vascular and nerve supply. This brings about, at the site and in the neighborhood of the obstruction, congestion, inflammation, and, if time is given, ultimate gangrene. The coils above the obstruction become dilated as a result of the accumulation of gas and feces, while below the obstruction the intestine collapses. In the chronic types, owing to the time element, opportunity is given for development of more productive change. In consequence of the obstruction, there will be more or less hypertrophy and dilatation of the wall of the intestine

above, with a narrowing of the lumen below the site of interference. The intestinal wall, and particularly the mucosa, is more or less involved above and in the neighborhood of the obstruction, becoming congested, ulcerated, and occasionally perforation or rupture, with subsequent peritonitis, occur. In the acute cases supervening on the chronic the changes are very similar to those described under the chronic type; that is, time having been given for productive phenomena in the bowel wall, but, in addition, acute inflammation or even gangrene may be superposed. Naturally, the findings will differ somewhat in view of the large number of possible causes, but in the main all of these gradations are comprised in the above statement. In those cases in which the circulation and nerve supply are interfered with, infection of both the strangulated loop and of the peritoneum takes place. There may be definite evidence of a diffuse peritonitis, with actual perforation, in consequence of the increased permeability of the strangulated loop. The strangulated loop is paralyzed, due to a combination of various circumstances, namely, interference with the blood-supply, injury to nerves, and, in part, as a result of distention. Vessels thrombose and the process eventuates in gangrene and perforation, unless relieved by operation.

PROGNOSIS.—In the vast majority of instances this is a matter of diagnosis, in the acute types especially. The earlier operative interference is practised, the greater likelihood of successful issue. In the chronic types, when due to malignancy, the outlook, of course, is prac-

tically hopeless, though even here, if recognized very early, resection may prove beneficent for a time at least.

Those types resulting from tumors of any of the intra-abdominal organs, the extramural type, or upon abscesses in the pelvis or about the appendix, or on renal or pancreatic conditions, will depend, of course, upon one's ability to relieve the underlying cause. A serious condition, frequently rendered infinitely more so by failure to recommend immediate operative interference whenever the suspicion of obstruction arises.

Recovery from intussusception following laparotomy and reduction can no longer be considered a surgical curiosity. In the last five years there have been successfully treated at the Children's Hospital in Boston ten times as many cases of intussusception as in a period of five years previous to 1908. The medical practitioner deserves part of the credit for this gratifying improvement for having brought the cases earlier to the hospital. In the future if he will bring still earlier and doubtful cases one can hope to determine the diagnosis with the aid of the X-rays in time to cause another marked reduction in mortality. Patients with intussusception operated on within thirty-six hours from the onset of symptoms may be expected to recover. W. E. Ladd (Boston Med. and Surg. Jour., April 10, 1913).

TREATMENT.—The most important factor in the treatment of any case of intestinal obstruction, more especially of the acute type, is to avoid the administration of purgative medicines. Even cases of fecal impaction, which is the only form of obstruction of the bowel which is not essentially surgical, should not be treated by purgative medicines

until attempts have been made successfully, by means of enemas, to relieve the condition.

Treatment, therefore, becomes a matter, first, of determining whether the obstruction is acute or chronic, and, if **acute**, absolutely all **forms** are **surgical**, with the possible exception of two. These are, first, the so-called paralytic ileus, which may be remedied by **saline injection**, and the results in this condition are sometimes surprisingly prompt, or if intussusception is suspected, attempts may first be made by means of **irrigations** into the bowel of **sterile salt solution**, or through attempts at **inflation** to relieve the invagination. Before adhesions form, this may possibly be successful.

It must not be forgotten, however, that both *irrigations and inflation* are not without risk, and that, if employed at all, they *should only be used very early* in the course of the case, and the greatest care should be exercised, for overdistention may rupture the bowel, particularly if inflammatory softening has occurred. **Postural or succussion methods** likewise require care.

Two cases added to the few on record in which menacing post-operative ileus was arrested as if by magic by **turning the patient on his stomach**. The occlusion is the result of traction on the mesentery of the small intestine, which drags down with it the superior mesenteric artery as it crosses over the duodenum. Rosenthal (Archiv f. Gynäk., Bd. lxxxvi, Nu. 1, 1908).

Treatment of intussusception by the **combined taxis and succussion** method is always to be **preceded by a rectal injection of water** to obtain the best results. The method is as follows: After the child is anesthe-

tized, the abdomen is bared and the hips raised by a small pillow. The tumor is grasped through the abdominal wall and firmly compressed for a few moments in order to reduce the swelling. Then the thighs are flexed on the abdomen, knees or legs grasped, and with a rapid up and down movement the lower part of the trunk is vigorously shaken for several seconds. The tumor is grasped again and compressed, and, while pushed against any part of the posterior abdominal wall, the fingers push or strip the intussusciptions out of the intussusceptum, the fingers at the same time making a trembling motion which assists in the reduction. After a few minutes of taxis the succussion is again resumed, and these efforts successively alternated. Sometimes, because of the mobility of the mass, taxis is not effective, and reliance must be placed entirely on the succussion or shaking. In all cases noted the tumors disappeared while the shaking was being done, although taxis had diminished the size of the swelling. J. Zahorsky (Arch. of Pediat., vol. xxviii, p. 380, 1911).

The diagnosis of obstruction once made or even strongly suspected, **operation** should be resorted to as promptly as possible. Until this can be done, **washing out the stomach with warm salt solution** may relieve vomiting and some of the distention which exists above the site of obstruction.

As to the propriety of using **opiates**, no harm will follow if operative interference has been decided upon, but great damage will be done if they are used to the point of obtunding the patient's sensorium, with the production of what might be called a period of deceitful calm. **Morphine**, hypodermically, and **gastric lavage** will allay pain and vomiting and prevent dangerous distention, and, in conse-

quence of this latter result, lessen some of the effects of vascular compression and spare the integrity of the bowel until the operation can be performed. The use of **atropine**, internally, may also be resorted to, $\frac{1}{50}$ grain (0.001 Gm.) or even $\frac{1}{25}$ grain (0.002 Gm.) by mouth, two or three times in twenty four hours being given.

Atropine has been successful to date in inducing a movement of the bowels in 100 per cent. of 56 cases of spastic ileus, and 95 per cent. of 20 cases of paralytic ileus, and in 68 per cent. of 54 cases of mechanical ileus. Schultz (Mitt. a. d. Grenzgeb., Bd. xvii, Nu. 5, 1907).

Three cases of severe ileus from paralysis of the bowels after major operations. The symptoms indicated a septic infection except that the tongue was healthy looking; $\frac{1}{64}$ grain (0.001 Gm.) of **physostigmine salicylate** was injected and immediately vigorous peristalsis was induced. Goth (Zentralbl. f. Gynäk., Dec. 19, 1908).

Atropine was found of value by the writer in 8 cases of paralytic ileus. In 2 patients, already in *extremis*, it was of no avail. A. Lederer (Med. Klinik, Jan. 2, 1910).

In cases of late operation for intestinal obstruction the writer **clamps** the lower segment of intestine and irrigates the upper as far above the obstruction as may be easily reached, using sterile water or half-strength salt solution. None of the material above must enter the empty and thirsty intestine below the obstruction. He then **clamps** the upper segment and slowly instils half-strength salt solution into the lower segment with a view to saturating it, guarding against later rapid absorption of harmful products. J. C. Johnston (Med. Rec., Jan. 2, 1915).

In postoperative ileus the writer always gives **pituitary extract** intramuscularly, 1 c.c. (16 minims) being

repeated every hour up to 3 doses, then every 2 hours, not exceeding 5 doses in 24 hours. This may be reinforced by a suitable enema. Gibson (Annals of Surg., Apr., 1916).

According to the writers **transfusions of dextrose solutions** are often of benefit in intestinal obstruction. Cooke, Rodenbaugh and Whipple (Jour. Exper. Med., June, 1916).

In cases of partial or complete obstruction of the lower colon and sigmoid unsuited for radical operation, the writer selects the right side for an **artificial anus** because it is readily made, admits of immediate drainage of the distended bowel above the obstruction, completely excludes the large bowel, and practically avoids odor. J. Y. Brown (Jour. Amer. Med. Assoc., Aug. 12, 1916).

In acute intestinal obstruction due to worms, not relieved by purgatives given orally, a **purgative enema** will often bring relief. J. M. Perret and H. T. Simon (Jour. Amer. Med. Assoc., Jan. 27, 1917).

Among the most difficult of all forms of acute obstruction to recognize are the internal hernias; indeed, one may say impossible of recognition clinically, and often requiring patient search on the operating table. For the surgical treatment of intestinal obstruction, see Volume I, page 62.

VISCEROPTOSIS.

SYNONYMS.—Glénard's disease; enteroptosis; splanchnoptosis. Descriptive of displacements of individual organs are the following terms: Nephroptosis, coloptosis, splenoptosis, hepatoptosis.

DEFINITION.—A dropping or falling of any or all of the abdominal viscera. In the majority of instances the stomach alone, or the stomach and right kidney, occupy lower posi-

tions than normal, and probably about as frequently as these the transverse colon is displaced downward. In some instances, however, all of the viscera come to occupy a lower position than normal.

SYMPTOMS.—Two groups of cases are found to exist, one in which the condition is acquired and the other in which it is congenital. The acquired cases often have a normal type of thorax, with a wide intercostal angle. These are, in the vast majority of instances, women who have undergone multiple pregnancies, or men or women who have been corpulent, but, having lost their fat, exhibit relaxation of the abdominal wall. The acquired types, whether occurring in men or women,—usually the former,—have a thorax of a tuberculous type, long vertically, with an acute intercostal angle and very little space between the last rib and the iliac crests. In general, patients with the acquired type complain especially of gastrointestinal disturbances, while those with the congenital type are apt to be classed among the neurasthenics. It is a curious fact that in some cases with very moderate ptosis marked general phenomena may be present, while others with the same or even a greater degree of ptosis may not be conscious of ill health, except that they note a tendency to exhaustion on slight exertion.

Visceroptosis is such a common condition that it furnishes the strongest argument for routine physical examination, both of the chest and the abdomen. It is not at all unusual for an individual the subject of this condition to pass through numerous hands, medical and even surgical, without the true nature of the condi-

tion being discovered. Faulty nutritional states, dyspepsia, constipation, vague pains throughout the body, backache, neurasthenia, fainting sensations after standing for any length of time, or more or less exhaustion after slight effort,—any or all of these may occur without recognition of the true cause. From the standpoint of the gastrointestinal tract the following manifestations are to be observed: Anorexia or a capricious appetite; a sense of distention, usually epigastric, occurring after meals; nausea, with or without vomiting; gaseous eructations; sometimes pyrosis and burning sensations beneath the lower end of the sternum or in the epigastrium, together with constipation, either alone or alternating with diarrhea, and in some instances mucous colitis. Cardiovascular symptoms are: Palpitation, cardiac irregularity from vagal irritation, vertigo, sensation of faintness, marked flushings, and pallor. The nervous phenomena are apt to be most bizarre. Often the dominating picture is that of the neurasthenic, with insomnia, melancholia, or periods of depression, alternating with brief periods of buoyancy, headache, and one very common complaint which may or may not be of nervous origin, viz., a dragging sensation with pain in the back and loins.

Patients with visceroptosis often state that they feel well from the waist up, but absolutely miserable below the waist. Probably many of the phenomena can be explained by disturbances in the abdominal circulation due to tension upon the vessels the result of prolapse, with consequent lowering of the organic function; in addition, there are likely

to be present symptoms resulting from vasomotor disturbances due to stretching of the splanchnics, as well as cardiac disturbances or motor disturbances of the stomach and small bowel, induced by vagus irritation. Cold hands and feet are the rule, and patients with this condition are apt to complain bitterly of the cold; the skin may even be clammy. One comes to associate a certain type of facies and physical conformation with visceroptosis. When the condition is of long standing, the patient is either absolutely apathetic or careworn and more or less wrinkled.

Very rarely one meets with a case in which a mechanical factor is responsible for the development of exquisite pain,—the so-called "Dietl crisis," simulating renal colic. This results from twisting of an unusually loose kidney upon its pedicle, with consequent torsion of the vessels, ureter, and nerves; intense lumbar pain, frequently radiating like that of renal colic. Chills, fever, nausea, vomiting, and collapse may occur. The urine, lessened in amount, may even occasionally be totally suppressed, and on examination the kidney may be found to be increased in size and tender (protopathic). Occasionally temporary hydronephrosis may add to its size. After the cessation of the attack, there may be an unusually large volume of urine; the urine often contains blood.

In the majority of women, even those who have never borne children, and in a small proportion of men, the right kidney may be felt on palpation during deep inspiration. This can scarcely be looked upon in itself as abnormal. When the organ is preternaturally movable, however, and

especially when the upper pole can be felt, the condition is to be regarded as distinctly pathological. This is best determined by placing the left hand over the flank, lifting the posterior abdominal wall up, with the patient in the recumbent position and well relaxed, while the fingers of the right hand are placed over the anterior abdominal wall, below the costal margin. The two hands are moved toward one another sharply during expiration. In this way, even in a stout person, slight mobility, of the right kidney especially, may be determined.

Splanchnoptosis and nephroptosis are frequently associated. In 68 patients the right kidney was down in all, the left kidney in 20 per cent, the stomach in 62 per cent., the colon in 62 per cent., and the liver in 7 per cent. Among females there was a marked ptosis of the uterus in some direction in 80 per cent. Smithwick (*Boston Med. and Surg. Jour.*, March 2, 1905).

Gastroptosis often exists without dilatation, but in the atonic cases more or less dilatation may be present. The stomach is vertical, often largely to the left of the vertical median line, and unless the pylorus is held up by adhesions it may come to occupy almost any position in the abdomen. The greater curvature, normally just above the transverse umbilical line when the stomach is empty, may under normal conditions be 1 inch or even 2 inches below the umbilical line after a meal, but in visceroptosis it may be actually down to the pelvis. Very light and superficial percussion is the best method to practice in order to outline it. Splashing sounds can in most instances be elicited for a considerable period after a meal.

The colon is much more difficult to outline; indeed, this is frequently impossible. If, as is sometimes the case, it is contracted, it may be felt, but this is quite the exception. It may be ptosed in the form of a "U" loop or a "V," in which case it is apt to form a sharp kink, especially at the splenic flexure, which, with the spleen, constitutes the area the least often disturbed of any of the abdominal viscera.

The liver is only exceptionally displaced, and can be outlined by very superficial percussion from above downward, or by placing the fingers of the left hand over the loins and the thumb anteriorly below the right costal margin while the right hand is used to make pressure upon the anterior abdominal wall, forcing up the viscera so that the anterior edge of the liver can be brought forward. In this way during inspiration the edge of the liver will ride over the thumb of the left hand. Occasionally Riedel's lobe, an abnormal, tongue-like process of the liver, may be felt anteriorly, giving the impression of a displaced right kidney or an enlarged gall-bladder. When the liver is markedly prolapsed, the cystic duct becomes more or less kinked and the common bile-duct also becomes obstructed to some degree, as shown by the late J. Dutton Steele. Thus are explained the various grades of jaundice occurring in this condition.

Occasionally, as was described in the section dealing with intestinal obstruction, gastromesenteric ileus may result through compression of the last portion of the duodenum by the root of the mesentery and its blood-vessels in consequence of extreme traction in advanced ptosis.

The pancreas may occasionally be felt if the patient can tolerate deep palpation in the epigastrium, midway between the xiphoid and umbilicus.

The cecum, particularly in long-standing cases, is often dilated and in the majority of instances falls over the brim into the pelvis. Bimanual examination in women will demonstrate a very low position of the uterus and the adnexa, the uterus often retroflexed, the fundus being felt in the *cul-de-sac*, the vaginal vault being less roomy than normally, with bulging of the anterior wall.

The abdominal wall in the majority of instances lacks tension, is unusually lax and quite redundant in the acquired forms, while in the congenital types there is a good deal more tension, no redundancy, and a scaphoid shape with prominent iliac spines. Even though the recti in any of these conditions may be capable of firm contraction, it will be found that the lateral walls, particularly, are utterly lax. Tender areas may be elicited here and there, and vasomotor paresis can be shown by the red line which occurs on the abdominal wall after scratching or other form of irritation. The lack of lateral abdominal musculature can well be shown, especially in those whose recti remain more or less normal, when in an attempt to rise from the recumbent position the intra-abdominal strain forces out the lateral walls, producing more or less bulging at the sides. In the congenital types especially there is an absolute lack of fullness in the epigastric region, or even a marked incurving. In the erect position the visceroptotic individual will show more or less prominence and fullness below the

transverse umbilical line, with flattening above.

In the congenital types, especially where visceroptosis is general, the diaphragm is depressed and the heart in consequence comes to occupy a lower position than normal. Probably as a result of this, the structures at the base and necessarily in the neck are subject to more or less traction, so that during cardiac systole a visible tug may be manifested, and during inspiration the cervical veins fill instead of empty, as shown by Wenckebach.

In marked cases there is very apt to be sighing respiration and the respiratory movements are suprathoracic, the lower portion of the thorax and epigastrium being motionless. In very thin individuals coils of small intestine may be visible, as may peristalsis.

At the present time X-ray examination renders a definite diagnosis a matter of great simplicity. A bismuth meal and a series of plates will reveal not alone the position of the various coils, loops, and flexures of the intestine, but also the time necessary for the passage of food through both small and large bowel, and in successful plates even solid organs may be outlined when the picture is taken after a purge, on a fasting stomach, and before the bismuth is administered. Gastric motility and the presence of kinks are easily revealed. Plates are not really necessary if one possesses a good-sized fluoroscopic screen.

Visceroptosis is now generally regarded as one of the predisposing causes of gall-stones, and it is possible, too, that renal calculus may be invited by the abnormal conditions

dependent upon renal displacement, though this is much less common than in the case of gall-bladder calculi.

DIAGNOSIS.—A knowledge of the two types, with the characteristic facies and a careful physical examination, will reveal the presence of ptosis of any or all of the organs. Nothing is to be gained by gastric analysis except in those instances in which dilatation with or without retention occurs. Early, gastric hyperacidity is the rule, though later free hydrochloric acid may be diminished or absent, and in few instances achylia gastrica occurs. It is no longer necessary to practise inflation of the hollow viscera, particularly the stomach, as the X-ray makes absolute diagnosis an easy matter. The definite relation between a floating tenth rib and visceroptosis to which Stiller called attention probably does not exist.

In ptosis of the cecum, pain, distention, and a sensation of dragging down are usually noticed below McBurney's point, sometimes more outwardly, but always near the iliac spinous processes. Palpation of the cecum gives the sensation of a soft, fluctuating tumor, which, upon percussion during a painful attack, shows dullness, with gurgling sounds when the attack subsides. A pathognomonic sign is the following: When the contents of the transverse and ascending colon are pushed back toward the cecum, pain in the right pelvic region is produced, while the pain disappears when the contents of the prolapsed cecum are gently pushed from below upward toward the colon. In milder attacks the ptosis is relieved by **dietetic measures, laxatives, massage, and exercise of the abdominal muscles.** Lardennois (*Presse méd.*, June 4, 1910).

Constipation is not invariably present in enteroptosis. Two signs the author associates directly with prolapsed intestine: 1. A tender point in the right semilunar line, generally an inch or so below the level of the umbilicus, but above McBurney's point. The tenderness is most marked on palpating backward and slightly inward toward the base of the transverse processes of the vertebrae. 2. A succussion splash in the "cesspool cecum"—very frequent and almost pathognomonic.

In advanced cases there is pain across the lower abdomen, between the iliac fossae. Often, especially where the stomach is dragged upon and lowered, pulsation of the abdominal aorta in the epigastric region is very marked. The aorta feels quite superficial. Dull abdominal pain or "feeling of weight" often accompanies the erect attitude and is relieved by lying down. Important clinically is the secondary implication of the stomach, leading to predominance of gastric symptoms. The abdominal crises attributed to neurosis or floating kidney are sometimes caused by enteroptosis. J. W. Smith (Med. Chronicle, May, 1913).

ETIOLOGY.—In considering the causes of visceroptosis it is necessary to bear in mind the two distinct types. The congenital type, with long, narrow, acute-angled thorax, prominent second rib, and other more or less pronounced manifestations of a phthisical conformation, can easily be shown to exist in several members of the same family, almost without exception with an ancestral tuberculous history. The acquired type results from repeated pregnancies, hydramnios, removal of enormous abdominal tumors, and improper corsets or tight lacing; or, in men and women alike, it may result from obstinate chronic constipation, prolonged coughing as in bronchiectatic individuals, after

possible recovery from ascites, and after the absorption of subcutaneous and intra-abdominal fat such as occurs after long wasting diseases. Diastasis of the recti, unless of tremendous degree, is not sufficient to invite the condition unless there is associated relaxation of the lateral muscle group, viz., the transversalis and obliques.

Whatever be the primary cause of visceroptosis, the end-result of the fall of the viscera and the stretching of the ligamentous attachments, with traction on vessels and nerves, is the same. Accumulation of blood in the abdominal venous system accounts for the cerebral anemia and syncopal attacks; or, when the condition is less marked, a sense of faintness occurs, especially when the patient is on her feet a great deal. This may also explain the insomnia complained of by many.

It has often been observed that the visceroptotic woman markedly improves during pregnancy, being totally relieved of her symptoms and even gaining weight. The explanation is twofold: The improvement is in part due to the lifting up of the viscera, and in part also to restoration of the function of the diaphragm; in consequence of these changes a restoration of the circulation takes place. The part played by the pelvic floor in supporting the abdominal viscera is almost a negligible one. The repair of perineal lacerations need not, therefore, be considered in the management of a case of visceroptosis. Rarely, long-continued intrathoracic conditions, as large exudates, new growths, or rarely a pneumothorax, may cause ptosis of the abdominal viscera by fixing the diaphragm in

the inspiratory position, thus interfering with its respiratory function and, in consequence, rendering more or less useless its muscular opponents, viz., the muscles of the abdominal wall.

Patients with chronic diseases of the lungs and pleura often suffer from enteroptosis, especially when there is a chronic cough and emphysema. The author has seen enteroptosis follow the emphysema caused by an unusually severe and prolonged attack of whooping-cough. Enteroptosis, temporary or permanent, also follows pneumothorax, pleurisy with effusion, and empyema. Such patients appear pale, with small, rapid pulse, cold extremities, general weakness, nervous instability, shortness of breath, palpitation, dizziness, digestive disturbances, and constipation. Splanchnic congestion is an important factor in these cases, for when treatment by **adhesive straps** or an **abdominal binder** is applied the symptoms usually improve. F. M. Pottenger (So. Calif. Pract., March, 1912).

Mechanism.—Although it is well known that Frantz Glénard first called attention to this condition in an exhaustive paper embodying his experiences at Vichy, the subject has not up to the present time received the wide recognition that it deserves. Large numbers of so-called neurasthenic individuals remain in disturbed mental and physical health solely because of a failure to recognize the true underlying cause. It might have been better had the term neurasthenia never been introduced into medicine. Glénard suggested the name *enteroptosis*, but Ewald preferred the term *splanchnoptosis*, because in fully developed cases not only the abdominal, but also the thoracic, viscera are the subject of more or less displacement.

We owe much to Dr. Arthur Keith for his splendid embryological and anatomical studies of this condition, and his findings have been largely drawn upon in the following: To appreciate the abnormal presupposes a recognition of the normal, and to this end certain boundaries and surface markings have been devised. Chief of these is the *sternoensiform line*, a transverse line passed through the junction of the sternum with the xiphoid. This marks the normal upper limit of the abdominal organs. The domes of the liver on the right and left sides fill the outer portions delimited by this line with the patient in the recumbent position, and fall a trifle below it when the individual is erect. The central tendon of the diaphragm lies about $\frac{1}{2}$ inch below the line, a little to either side of the median vertical line of the body. This line forms the basis of measurement by which we estimate the extent of actual ptosis. Normally it crosses the fifth costal cartilage on each side; the fifth space in the emphysematous, in which case the ribs are more horizontal, and the fourth interspace or even the fourth rib in the phthisical type of chest, in which the position of the ribs is very oblique, with a narrow intercostal angle. The second landmark, known as the *transpyloric line*, was described by Dr. C. Addison. It is a transverse line passing through a point midway between the umbilicus and the sternoensiform line, the so-called midepigastriac point. Normally, this line meets the costal margin near the outer border of the rectus muscle of each side, crossing the ninth cartilage. In its normal position the pylorus is found immediately under this line;

about midway between the midepigastric point and the right costal border. Abnormally, the pylorus may come to occupy almost any position, as has previously been stated, but the actual degree of displacement can be determined from the above facts. The lesser curvature is normally $\frac{4}{5}$ to 1 inch above the transpyloric line, and the greater curvature in the midline of the body, $1\frac{1}{5}$ to $1\frac{1}{2}$ inches below it. Behind the line lies the pancreas, and normally the liver is always above it. The third line is one drawn transversely through the umbilicus, the so-called *transverse umbilical line*, which is almost identical with the line drawn across the highest points of the two iliac crests. Normally, the transverse colon occupies a position in the midline just above this landmark. The right kidney is normally situated a little lower than the left, but its lower pole is $1\frac{1}{5}$ inches above this line, and in the case of the left kidney $1\frac{2}{5}$ inches above. Abnormally, the lower pole, of the right kidney especially, may be felt below this line, tilting toward the median vertical line of the body.

In the recumbent position the upper border of the liver on the right side reaches the sixth rib in the mid-clavicular line, anteriorly the eighth rib in the midaxillary line, and posteriorly the tenth rib in a line with the inferior angle of the scapula, while its lower border anteriorly is delimited by the costal margin. The hepatic flexure of the colon is just within the right anterior axillary line under cover of the tenth and eleventh costal cartilages and liver, its upper border being just below the transpyloric line. The splenic flexure extends above the transpyloric line on

the left side, just within the left anterior axillary line, and with the spleen and left kidney constitutes the most fixed region within the abdomen.

Various factors have been brought forward to account for the normal maintenance of position of the abdominal organs. By some, the ligaments are held to be of the greatest import. That this is erroneous, however, can be readily shown by holding a cadaver in the erect position. Provided the body is not frozen or at least cold enough to render rigid the abdominal wall, it will be found that the viscera chiefly concerned in ptosis, viz., those above the transverse umbilical line, at once prolapse. If now the abdominal walls are cut and reflected, though the ligaments remain intact, more marked ptosis occurs. This I have observed some hundreds of times in the making of necropsies, and it seems conclusive evidence that the chief factor must be the abdominal wall. Were the ligaments responsible, the erect position would of necessity cause traction during life, with consequent disturbance of both vascular and nervous structures contained within them. As has been previously stated, the muscles mainly concerned in this support are the transversalis and obliques. This can be best observed in the individual whose recti happen to remain in normal tonus while the lateral muscles wholly or in part lack their tonus. When such an individual attempts to rise from the supine to the sitting posture without using the hands, it will be noted that the lateral regions yield very materially, causing prominences to appear on each side. Likewise during coughing, with an intact abdominal wall the supraumbilical

viscera during forced expiration are driven up into the hypochondriac region, forcing the diaphragm upward and compressing the thoracic viscera, while the infraumbilical viscera are forced downward. With lax muscles which have lost their tonus, this does not hold true.

The study of a case of visceroptosis is best accomplished by theoretically dividing the abdomen into two portions, with the transverse umbilical line as the dividing line separating it into supra- and infra- abdominal regions. The organs in the upper area, viz., the stomach, duodenum, transverse colon, kidneys, especially the right, in some instances the liver and pancreas, and very rarely the spleen, are the parts especially involved. Normally, too, the muscles of the abdominal wall in the upper area act as opponents of the diaphragm, so that, as Keith states, in thoracic respiration these muscles serve under normal conditions as a shelf or support for the contained viscera during inspiration, thereby aiding the diaphragm in the elevation of the ribs and thorax. The muscles of the infra-abdominal region normally play a minor part in breathing, but they do furnish some support for the supraumbilical contents. With the relaxation of the lateral muscles of the abdominal wall, this normal relation is lost.

Many children coming under the author's care for hernia due to excessive intra-abdominal pressure showed marked enteroptosis with diastasis of the recti and pendulous abdomen. Relief of the abdominal pressure not only cured the hernia without operation, but also greatly relieved and often cured the enteroptosis. Besides overcoming constipation by diet, etc., he had them go to

bed at 6 and **sleep with the head lowered** in a sort of **Trendelenburg position**, the intestines thus gravitating toward the diaphragm, and enabling the supporting structures to recover from the strain. Enteroptosis is the cause of trouble only when it causes obstruction, which may be due to more or less marked angulation or even torsion. Seventy-five per cent. of the foreign-born working women, multiparae, have right-sided nephroptosis, but this causes no trouble unless it produces obstruction of the ureter and overdistention of the pelvis. A stomach of good motility should never be operated on, and enteroptosis of the small intestines is still less important unless complicated with adhesions. In the greatly exaggerated condition of Hirschsprung's disease **excision** is invariably indicated, preferably by **Judd's method**. A. J. Ochsner (Jour. Amer. Med. Assoc., Nov. 26, 1910).

PATHOLOGY.—It cannot be stated that there is any definite pathology other than the relaxation of the musculature of the abdominal wall, and in time also impairment of the diaphragm. The involved viscera may become congested, and the liver especially may become additionally enlarged on that account. In advanced cases in which the stomach is very greatly ptosed, it becomes more or less atonic, with consequent dilatation and retention.

PROGNOSIS.—The milder grades, particularly those which are acquired, yield more or less readily to appropriate treatment, so that, in general, the statement is justifiable that the prognosis is good. In the congenital types, however, the outlook is less favorable. Recovery depends in so large a measure upon the volitional aid of the patient, and this is so difficult to obtain in many instances, that a rather larger proportion of these

individuals drift into a state of more or less complete invalidism, and unfortunately the profession at large so seldom recognizes the true nature of the case that finally, in addition to the morbid entity, the patient may be said to suffer also from a complication of doctors.

TREATMENT.—The management of a case of visceroptosis depends, in part at least, upon the type of abnormality present. In the acquired form **mechanical support** that really accomplishes its purpose will give very prompt relief. As the nervous manifestations are usually less pronounced than in cases of the congenital type, it will usually prove sufficient to apply a well-fitting **binder**, such as the Rose or the Storm binder, or even a **two-piece corset** of which the lower portion constitutes an abdominal belt, or a corset in one piece provided with an abdominal binder which fits inside the corset, passing out through perforations, so as to permit of adjustment. The Spencer corset is an excellent illustration of this type.

The tests of a properly fitted corset for splanchnoptosis are: 1. The front steel must always overlap the upper border of the symphysis; the lower part or suprapubic area must be flattened and fit so snugly that when lying down the fingers can barely be inserted between the corset and the bone. 2. The replaced stomach should be noticeably prominent within the upper portion of the corset. 3. On rising, sitting, or walking, the corset should not "hitch" upward. 4. The wearer should experience an almost immediate sense of support and comfort. E. Gallant (Lancet-Clinic, May 11, 1912).

In the weak and exhausted cases **rest in bed** for some time may be

necessary, and it is often advantageous to **elevate the foot of the bed**. After relief has been procured from the results of abdominal and pelvic congestions, a well-fitting **binder** should be applied and the patient allowed to get up. **Correction of any constipation or digestive disturbance** should be effected, and for a considerable period it will be necessary for the patient to secure ten to twelve hours' **rest** daily.

In prolapse of the cecum a kink is sometimes formed in the ileum near the ileocecal valve. Fermentation takes place and the entire small intestine may become distended, producing discomfort or severe pain. In the treatment of this condition **licorice powder** is of great service, especially in conjunction with a **diet** largely of vegetables; likewise, **agar-agar**. When colitis is present small doses of **phenyl salicylate** and **castor oil** are of value, and when toxemia exists great help is afforded by the exhibition of **calomel** once a week. J. M. Jackson (Boston Med. and Surg. Jour., Sept. 12, 1912).

The congenital type, and less frequently the acquired type, present a nervous symptom-complex which is often one of the most difficult of the entire condition to deal with. Mechanical supports, such as the usual binder or corset, are frequently of no value in this type, owing to the prominent iliac bones and scaphoid abdomen. Under these circumstances support can be obtained only by the application of **adhesive plaster straps** wider at their lower anterior end than at the upper and posterior. They should be long enough to cover about three-fourths of the body circumference, and the first should be applied in the iliac regions; to the right, to be carried beneath the left iliac crest

and passed beyond the spine posteriorly. The corresponding opposite strap should be placed over the left iliac region, and carried obliquely beneath the right iliac crest and beyond the left side of the spinous processes. Two others, with the broad portions below, placed just above these are then carried above the left and right iliac crests to fasten posteriorly, each being long enough to reach beyond the spine. Before this is done, it is advisable to place the patient absolutely at rest and completely relaxed, with the head low and the hips well elevated, then to lift the abdomen as much as possible, and finally to apply the retaining zinc oxide plaster. This binder may be kept on from two to four weeks; and after it is taken off, the skin should be bathed with turpentine to remove the old plaster, this being followed, in turn, by a soap and water cleansing bath and a final sponging with alcohol. If the skin is chafed, twenty-four hours should elapse before a bandage of similar construction is reapplied.

Advantages of **knee-elbow position** for correction of visceral ptosis emphasized. Case of recurring pain, nausea, etc., due to movable kidney in which as soon as the patient, a young woman, assumed the knee-elbow position she experienced relief. She learned to use this as a prophylactic measure, *e.g.*, before going out for a walk. The pains come on when the stomach content is being passed on into the intestine, the latter being compressed by the movable kidney. Fellenberg (*Correspondenzbl. f. schweizer Aerzte*, March 1, 1911).

In the writer's 500 cases, primary or independent chronic excessive toxemia was met with in 50 per cent., secondary, or dependent upon the ptosis, in 24 per cent., and toxemia-

free 26 per cent. Therefore, 50 per cent. of all cases have one of the forms of primary chronic intestinal toxemia, and unless this is controlled recurrence of symptoms is very liable to happen in a few months' time. This requires dieting according to the toxemia present, **high protein** for the saccharo-butyric, **carbohydrate** for the indolic, and carefully **weighed diet**, so there is no excess, in the mixed forms. **Vaccines** are essential to bring results about, these always being autogenous, and used in bold doses, the selection being according as the bacteriology of the gut is off from normal standards. At least 90 per cent. of these most difficult ptosis plus primary toxemia cases are curable by vaccines and diet.

A few cases are surgical. All distinct cases considered, the number requiring surgery represents about 1 per cent. When decided upon, a careful clean-up of angulations, adhesions, bands, as well as suturing the organs in higher position, are required. But even with these it is well to treat them medically for some time after operation. Anthony Bassler (*Med. Record*, Dec. 21, 1918).

After correcting constipation and dietetic errors, securing uninterrupted sleep each night, and at the same time urging the ingestion of **food of high caloric value**,—soups, broths, and liquids in any amount being avoided,—it will be found in the majority of instances that considerable improvement has been obtained. **Abdominal massage and general massage**, including some **resistance movements**, will considerably hasten improvement, but complete recovery is only possible either through deposition of fat or by the improvement of the lateral abdominal muscle group, which constitutes the natural support.

Following treatment recommended in cases of moderate abdominal ptosis: Three times a day, after



Physical exercises for enteroptosis. (*W. Egbert Robertson.*)



meals; the patient should lie down for half an hour on a **flat, hard mattress without** a pillow under the head, but with a **small pillow between** the shoulder-blades. At least once a day an **exaggerated Trendelenburg position** should be assumed by raising the foot of the bed or sofa. **Shoulder-braces, massage, and light, graded exercise** to improve the muscles, especially those of the back, abdomen, and shoulders, are also to be ordered and the patient should wear continuously, except when in bed, a proper **abdominal support**. Mumford (Boston Med. and Surg. Jour., Aug. 10, 1911).

Résumé of the **rest-cure treatment** of movable kidney and associated ptosis: *First to third day.* **Rest in bed, with foot of bed elevated.** Snug abdominal binder worn continuously. **Chloral and bromide** or other hypnotic to secure eight to twelve hours' sleep. **Spring water** every hour. **Gentle friction over trunk; kneading abdomen** once daily. As tonics, **digitalis, strophanthus, and iron.** **Soapsuds enema and castor oil.** *Fourth day.* Same except add **fluid diet** every two hours, and **saline laxative** in hot water, 6 A.M. daily. *Fifth day.* Same, except substitute **passive motions** for massage, and change tonic to tablets of **iron, arsenic, quinine, and strychnine**, 1 to 4 after each meal. Do whatever reparative operative procedure is necessary on cervix, perineum, tubes, ovaries, rectum, bladder, nose, and throat. Examine eyes; no reading until glasses are fitted, if necessary. *Seventh to twenty-eighth day.* Still in bed, and measured for **corset**. On *fourteenth* day begin semisolid nourishment every three hours. On *twenty-first* day begin **active resisted movements**, and **casgara and hydrastis** as cathartic. *Twenty-fifth day.* Still in bed; mixed diet three times a day, liquid food between meals. **Calisthenics.** *Forty-second day.* Corset to be put on before getting out of bed. E. Gallant (Lancet-Clinic, May 11, 1912).

For some years I have employed with more or less advantage a series of **exercises**, but whenever possible I have prevailed upon patients to join a good gymnasium, where in addition to deriving the benefit of the exercise itself they are subject to the unconscious influence of healthy stimulation and emulation. I am indebted to Dr. W. J. Schatz, Physical Director in the Department of Physical Education of Temple University, Philadelphia, for the following consideration of exercise treatment in visceroptosis: Physical exercises which make for permanent widening and deepening of the chest, for strengthening and shortening of the abdominal muscles, and for proper poise of the body bring about mechanical conditions which favor support for the abdominal organs. During the exercises little clothing should be worn: none that constricts the waist or limits any movement should be allowed. Pajamas and stockings or a gymnasium suit serve the purpose well. Exercises should be done in the morning before breakfast and in the evening before retiring, their number being increased as the general condition and strength of the patient warrant.

The exercises are shown in the annexed illustrations:—

Figure 1 shows the best position for the patient. Several blankets are placed on the floor so as to form a pad several inches higher at the hips than at the head. With the patient's knees flexed, the abdominal muscles are relaxed, and gravity favors reposition of the organs. The patient then places both hands on the abdomen, the ulnar borders being parallel with Poupart's ligaments and just above

them. After full expiration, the glottis should be closed and the movement of inspiration made by forcibly lifting the chest, thus forcing the entire abdominal contents upward toward the diaphragm. At the same time, the abdominal contents should be manually lifted, and the arms then rapidly raised over the head laterally, thus further increasing the expiratory effort. Relaxing, the patient now assumes the first position, takes several breaths, and then repeats the movement.

Figure 2 explains the next exercise. The patient, lying in the same position, elevates both legs, keeping the knees stiff and the toes pointed in extension. The exercise is repeated half a dozen times. This is at first difficult, and is followed by a certain amount of abdominal soreness, which soon subsides with continued exercise. Though strengthening the abdominal muscles, this exercise does not shorten them materially, as their action is mainly that of fixing the pelvis while the flexors of the thigh raise the leg.

Figure 3 shows the next position. During this exercise the legs should be kept constantly flexed upon the thighs. Beginning with the first position (Figure 1), except that the arms are employed to assist in elevating the hips, and with the legs flexed upon the thighs, the thighs are then forcibly flexed upon the pelvis. The last stage of this upward pull should be done rather forcibly. The position should be maintained for one-half minute, the patient then returning to the first position. The exercise is repeated several times.

In each of the exercises thus far described the pad may be lowered

as the patient's strength increases, until a horizontal position is reached. A pad, however, will always be necessary, in order to avoid bruising the tissues over the spine.

Figure 4 illustrates the exercise especially designed to strengthen the lateral muscle group. Starting with the position shown in the second figure, but with the arms extended obliquely outward and the legs kept extended upon the thighs, the patient allows them to drop first to one side, to the left, as shown in Figure 4, then again at right angles to the trunk, preparatory to dropping them to the right. This exercise should be continued alternately to the right and left until the muscles tire.

Figure 5 illustrates the "turnstile movement." In this the arms are carried alternately up and down, always extended, as shown in the figure.

It is of importance to preserve the lumbar curve, which the exercise shown in Figure 3 does not tend to do. It is probable that the anterior projection of the spinal column in the lumbar region acts somewhat like a shelf, more or less supporting the abdominal viscera above. Figure 6, accordingly, is designed to do this. The patient, lying prone, raises the upper and lower extremities of the body sufficiently to be able to imitate the movements of the breast stroke in swimming, as far as the arms are concerned. With the back arched, the knees slightly flexed, the arms are brought forward with a lateral swinging movement to a point as far front as possible. This is repeated several times.

The next exercise is designed to elevate the chest with a view to per-

manent lifting of the abdominal contents, at the same time increasing the capacity of the upper abdomen by broadening the waist. In Figure 7 the subject is shown seated on a chair, with knees separated and hands resting on the thighs, close to the body. The chest is then elevated as high as possible, held in that position a few moments, then allowed to sink by relaxation. No attention need be paid to the breathing while performing this movement, as it is not intended as a breathing exercise. It is intended to raise the chest upward and forward as far as possible, thus developing the muscles concerned in this act and stretching the structures which oppose elevation of the chest.

Figure 8 shows a general exercise the object of which is to improve the general body tone, the muscles of the legs and thigh especially, and, further, to increase the tonicity of the cardiovascular apparatus. The abdomen should be drawn in throughout the exercise, the patient alternately rising to the erect posture and then assuming the position shown in the figure.

Cases of ptosis due to a congenital habitus are not relieved by operation, except rarely. In cases following childbirth resection of the relaxed ventral tissue through the method suggested by Webster may give perfect relief provided the diastasis has not been of such long standing that the abdominal organs are far below their normal levels. In the latter case, in addition to the **Webster operation**, it may be necessary to suspend the colon by means of the omentum, thus relieving the stomach of the weight of this organ, and at least temporarily supporting the stomach until there may be a natural shortening of its ligaments. In a simple gastropptosis without marked participation of the colon

the **Beyea operation** may be the one of preference.

In exaggerated cases of ptosis of the transverse colon, with fecal stasis and a tendency to twisting, causing symptoms of partial obstruction, nothing less than **excision of the redundant loop with end-to-end anastomosis** will cure. In redundant sigmoid, with more or less constant pain in the left side, and obstinate constipation, **suspension of the sigmoid** may give entire relief, though, on account of the constant mobility of the sigmoid, a recurrence may be noted. In exaggerated cases of redundant sigmoid, with extreme constipation verging on to obstruction, **resection of the sigmoid** may be advisable. In all cases a carefully fitted **abdominal support** or corset should be worn after operation. J. G. Clark (Surg., Gynec. and Obstet., April, 1908).

In prolapse of the cecum symptoms resembling appendicitis with constipation are sometimes present. In addition to **appendectomy**, the **caput coli** should be **anchored in its normal position** as follows: The reflection of the parietal peritoneum on to the mesocolon is nicked with scissors and the incision extended downward parallel with the cecum as far as the brim of the true pelvis and upward for 4 or 5 inches. The peritoneum is stripped away from the mesocolon and from the posterolateral wall of the false pelvis. Into the pocket of peritoneum thus formed in the right iliac fossa at the normal site of the caput coli the caput is placed and there secured by catgut, sewing the edge of the peritoneal flap to the middle white line of the caput. The lowest suture is placed about 1 inch above the site of the base of the appendix. Two other sutures are placed above at intervals of 1 inch. Thus the caput is securely fastened in a large pocket, the lining of which must rapidly become adherent to the intestinal peritoneum. R. S. Fowler (N. Y. State Jour. of Med., July, 1911).

Among 400 women suffering from visceral ptosis, the writer found digestive symptoms in 21 per cent.; backache and abdominal dragging in, respectively, 18 and 24 per cent.; nervous symptoms in 20 per cent.; organic disease outside of the alimentary tract in 19 per cent.; and constipation in 68 per cent. Treatment of the ptosis itself is obviously indicated in less than 25 per cent. of such cases. Surgery is rarely required. Most are benefited or cured by proper **dietetic** and **hygienic** treatment. Constipation which occurred in 68 per cent. of this series is curable by dietetic and medicinal treatment. It is the patient and her entire condition, not alone the ptosis, that one must treat. In many cases the abdominal support upon which so much dependence is placed, does not support. The benefits derived are purely mental. The nervous or mental element is often the most difficult feature to overcome. Some seem to believe that by overcoming the ptosis, the symptoms will disappear. That such is not the case is proven by the failures of surgery in these cases. The ptosis is quite as often the result as the cause of the general condition of these patients. Hence the treatment must be directed to all of the patient's physical and mental ills. Chase (*Boston Med. and Surg. Jour.*, Aug. 30, 1917).

If there were no brilliant surgical successes in these cases no surgery would be done; but, on the other hand, if the internist always satisfied the patients none would go to the surgeon. If one gave due consideration to the subject of ptosis he would find that most of the "acquired cases" had also stigmata of decline—they belonged to the vagatonics, with stigmata of degeneration, such as a high arched palate, defective ear or scapula; and ptosis was one of the stigmata. R. T. Morris (*Trans. Med. Soc. of Co. of N. Y.*; *Med. Rec.*, Dec. 21, 1918).

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INTESTINES, DISEASES OF THE (CONTINUED).

INTESTINAL STASIS; COPROSTASIS.

DEFINITION.—"An abnormal delay in the passage of the intestinal contents through a portion or portions of the gastro-intestinal tract, and, as a result, the absorption into the circulation of a greater quantity of poisonous or toxic material than can be treated effectually by the organs whose functions it is to convert them into products as innocuous as possible to the tissues of the body." (Sir Arbuthnot Lane.)

SYMPTOMS.—Although intestinal stasis is usually believed to be associated with constipation, such is not the case; daily and satisfying intestinal movements may occur and yet marked intestinal stasis with its specific symptoms be present. In most cases, however, constipation, sometimes persistent and rebellious to the usual forms of treatment, occasionally diarrhea and more or less severe headaches are complained of.

Nausea and often vomiting, occasionally streaked with blood, and accompanied with epigastric pain, eructations, anorexia, more or less foul breath and emaciation, a coated tongue, abdominal distention with pain, flatus and borborygmus are commonly observed. The pain is often located about the right iliac region with tenderness on pressure in this location and over the hepatic flexure of the colon, in the neighborhood of which a sensation of gas distention, movable under the palpating fingers may usually be obtained. The cecum may often be outlined also through the presence of gas therein; cecal splashing may also be elicited in some

cases. The areas of fixation are often the seat of tenderness.

In a series of 136 cases of chronic intestinal stasis studied by the writer, constipation was noted in 84 per cent. and diarrhea in 30 per cent. In 6 per cent. bowel movements were normal. Colica mucosa occurred in 43 per cent., marked flatus in 76 per cent., loss of weight in 60 per cent., mental symptoms (from simple inefficiencies to melancholia, epilepsy, delirium and stupor) in 40 per cent., and nerve symptoms (neuralgias, etc.) in 65 per cent. Motility was ascertained from the X-ray. Intestinal ptoses may exist to any degree without causing symptoms. Enteroptosis was absent in only 22 per cent. Gastric constipation, determined by remnants of the bismuth or barium meal 6 hours after ingestion, was noted in 54 cases, and ileal constipation in 3. Obstruction by Lane's kink was relieved by operation in 1 case. Cecal constipation, determined by remnants of bismuth or barium 48 hours after ingestion, was present in 42 per cent., and apparently responsible for much of the symptomatology. Colonic delay of 48 to 72 hours was noted in 9.5 per cent., and of 72 hours or over in over 50 per cent. Sigmoid constipation, the sigmoid failing to empty in 3 days, was noted in 34.5 per cent., and associated with cecal constipation in 16 per cent. Of the entire series, 25 per cent. had had their appendices removed without lasting benefit to the chronic condition. G. R. Satterlee (*Amer. Jour. Med. Sci.*, clii, 727, 1916).

The general phenomena of intoxication may occur in cases in which the foregoing symptoms are not prominent. They consist of a sallow skin, more or less yellowish or brownish sometimes in patches, the familiar "muddy complexion" with rings about the eyes, general malaise, defective circulation as manifested by cold

hands and feet, mental apathy, marked lack of energy and physical endurance, lassitude, general myasthenia, fetor of the sweat, sometimes of the whole body but particularly in the axillæ and groin, which may also become brownish, myalgia, generalized or located in the back, left hip, flank or subscapular region, stiffness of the joints, urethral irritation on micturating, coccygodynia, and a tendency to insomnia.

Many sufferers from neuralgia, neuritis, migraine or hemicrania, neurasthenia, irritability, epilepsy, convulsions, vertigo, hysteria, and even coma owe their trouble to intestinal stasis. Likewise, various psychic disorders, excitement, hallucinations, mental confusion and psychasthenia, particularly in the predisposed. Even dementia precox may find its preliminary cause in intestinal stasis.

[In a personal case of so-called epilepsy in a child of 7 years, in whom an average of 3 epileptic fits occurred every night, intestinal lavage, with alternating position from the knee chest to the right side as soon as the warm water was injected to insure its gravitation to the cecum, and left there 20 minutes, repeated nightly, with $\frac{1}{4}$ grain (0.016 Gm.) of desiccated thyroid gland as sole remedy, sufficed to insure recovery, now of 3 years' standing. In another personal case, one of dementia precox so severe that the patient, a boy of 16 years, had to be kept in a straight jacket and bindings, recovery was obtained by flushing the cecum through an opening in the latter, with lecithin as main remedy. This phase of the problem is reviewed at the end of the article on DEMENTIA PRECOX, Vol. III, page 760. C. E. de M. S.]

It appears to be proven without doubt that recurrent iritis has its origin in chronic intestinal stasis. Case of a woman of 32 years who had suffered for 14 years from recurrent iritis, rheumatism, and a vertebral polyarthritides. She has remained well

for 3 years and gained in every way since the removal of a chronically ulcerated appendix with concretions and the breaking up of adhesions around the cecum. When a case has become progressively worse under medical treatment, surgical procedures directed to the intestinal tract are indicated. Many chronic eye lesions cannot otherwise be cured. H. M. Thompson (*Jour. Ophthalm. and Oto-Laryn.*, xi, 343, 1917).

DIAGNOSIS.—Beside the foregoing phenomena many of which may be discerned in all cases, the location of coprostasis must be determined. As previously stated, the seat of retention, if within reach of the palpating fingers, is often sensitive under pressure, while it may also be the seat of accumulated flatus movable under pressure with perhaps a history localized, at times painful or "colicky" borborygmi. According to Sir Arbuthnot Lane and his school, kinks of the intestine, adhesions and bands formed especially in the neighborhood of the ileocecal valve, the gall-bladder and the sigmoid flexure of the colon, may produce stasis mechanically.

Keith has urged that other areas are subject to stasis owing to spasm of certain muscular elements concerned with peristaltic contractions. He holds that the outer longitudinal and inner circular layer of involuntary muscle fibers are innervated by a sympathetic paraganglionic plexus lying between them, the myenteric or Auerbach's plexus, corresponding in structure to the cardiac atrio-ventricular bundle and that its function is to act as pace-maker for the peristaltic contractions. Aggregates of this plexus—whose structure is intermediate between nerve and muscle—form nodes in certain regions: the cardiac

orifice of the stomach, the entrance of the common bile duct, the duodenal-jejunal angle, the ileocecal junction, the point of union of the proximal (the cecum and ascending colon) and transverse colon, and finally the descending colon. Of these the ileocecal junction is that most likely, owing to its sphincter-like structure, to offer spasmodic mechanical obstruction to the fecal contents. While Keith states that X-rays have failed to indicate obstruction at bands and kinks, as held by Lane, the evidence is fairly complete that derangement of the musculature of the ascending, transverse and descending colon exists, characterized by marked increase in the tonus of the segments, sufficient in some instances to spastic contraction and obstruction.

The X-ray studies of Case and the operative results of the writer led the latter to believe that the cause of ileac stasis lies in an incompetency of the ileocecal valve rather than in the Lane kink, and that the latter is nothing but an embryonic structure and without significance. The various other membranes and adhesions found in the ileocecal region are probably due to a localized slow peritonitis due to the stasis in the ileum. The evidences of incompetency are shown by the fact that at operation he was able to force gas by pressure from the cecum into the ileum. In such cases as a rule, the terminal portion of the ileum is found to be distended to twice or more the usual diameter; furthermore it is thickened. It must be remembered that the cause of the incompetency is some obstruction lower down in the colon, usually adhesions of the pelvic or ileac colon. Sometimes, a neoplasm is found or a tubercular or syphilitic ulceration. Short circuiting of the bowel as practised by Lane is usually attended by a recurrence of the symptoms. On the other hand, the writer's

operation, consisting in restoration of the ileocecal valve and removal of the distal obstruction is attended by complete cure. J. H. Kellogg (Med. Record, Sept. 8, 1917).

DIAGNOSIS.—Diagnosis of stasis anywhere in the gastrointestinal tract is best accomplished by giving a barium sulphate meal—2 to 3 ounces (62 to 93 Gm.) in a pint of buttermilk—and observing its progress fluoroscopically and röntgenographically in its passage from the mouth to the anus. Additional information is also obtained by examining similarly after the use of a barium sulphate enema after cleansing out the colon an hour before the examination. The oral use of barium does not require preliminary preparation, the patients being allowed to follow their usual habits, even to the taking of their habitual laxative, if such be their custom. This avoids disturbing the conditions to which the symptoms and their causes are due. When gallstone is suspected, however, a purgative should precede the examination, to avoid confusing and misleading shadows in the colon.

The main points to be noted are the duration of the passage of the barium meal, minutes, hours, etc., to reach fixed landmarks, such as the ileocecal juncture, the cecum proper, the ascending transverse and descending colon to the anus. It should have passed completely at the end of 30 hours. If this period is prolonged, the seat of retention should be sought, watching out also for kinks, bands, adhesions, fixations, etc., capable of strangulating the intestine, as shown by the shape of the latter; and also for modifications of outline, the transverse colon particularly, which may

be elongated and assume the shape of a hammock or even of a U and the descending colon, which may take on almost any kind of shape,—a complete coil as in one of my own cases—and offering ample opportunity for retention. In keeping with Keith's researches, referred to above, delay in the progress of the barium meal may be noted at the cardiac and pyloric orifices of the stomach and the duodeno-jejunal junction. Where anti-peristalsis is most active in the transverse colon, about its anterior third, a constriction ring has been described by Cannon, which may be the seat of obstructive constriction. This anti-peristalsis may in fact keep the cecum filled several days and prove a source of active intoxication.

Four examinations are usually made under the fluoroscopic screen, at intervals of 6, 8, 20 and 30 hours. At the end of the sixth hour the barium has passed entirely out of the stomach and is generally found in the cecum and ascending colon with a remnant in the terminal ileum. About the ninth hour it reaches the splenic flexure of the colon and enters the rectum about the end of the twenty-fourth hour.

A careful Röntgen study furnishes the most valuable evidence as to the actual pathological conditions present in the gastro-intestinal tract, associated with intestinal stasis. The most constant factors are rectal retention and secondarily retention in the pelvic colon with elongation of the pelvic colon and transverse colon, dilatation of the ascending colon, atony, and incompetency of the ileocecal valves, resulting in regurgitation into the ileum, and absorption of the contents. A spastic condition of the bowels is present in the majority of instances, and this is aggravated

by irritative laxatives, to which class most laxatives belong. The spasticity may be caused by appendiceal or gall-bladder disease. G. E. Pfahler (Med. and Surg., July, 1917).

The main points with reference to the radiographic aspect of chronic intestinal stasis are: (1) The length of period that the meal remains in the stomach, the behavior of the stomach, the mode of emptying. (2) The size and shape of the duodenum, the mode in which it evacuates its contents, the form of the duodeno-jejunal junction. (3) The length of time the meal remains in the ileum, the mode of its evacuation, the degree of thickening of the walls of the terminal coil, the relation of the appendix to the end of the ileum, the evidence of the presence of an ileal kink. (4) The size and position of the cecum, with possible indication of its rotation. (5) The mode of passage of the meal through the large intestine, the limitation by a band of the caliber of the bowel about the junction of the cecum and ascending colon in the transverse colon, just below the gall-bladder where the acquired ligament is attached, which connects the gall-bladder to the pylorus duodenum, transverse colon at the splenic flexure, and at the last kink at the left pelvic brim. The form of the bowel must be examined with a view to determine the presence of inflammation of its wall or of diverticulitis. The shape and size of the pelvic colon should also be carefully observed both in the case of the meal and in that of the enema, since this is a factor of the greatest importance. The presence or absence of gall-stones should be noted. Sir Arbuthnot Lane (Practitioner, Mar., 1919).

Examination of the rectum and sigmoid flexure by means of the proctosigmoidoscope affords considerable assistance, a large proportion of disturbances being located in the area within its reach, ulceration, growths,

contractures and spasms being readily discerned.

The main conditions with which intestinal stasis may be confused are chronic appendicitis, salpingitis, angiocholitis, enteritis, latent tuberculosis and neurasthenia. Diarrhea is not an indication of the absence of stasis; in fact, some severe cases of stasis are accompanied by this symptom, which probably represents an effort of Nature to facilitate the elimination of toxic materials by liquefying them.

TREATMENT.—Sir Arbuthnot Lane is generally thought to advocate colectomy in intestinal stasis; but his true attitude is that 90 per cent. of these cases should be treated medically. When it is shown by the Röntgenogram that, as is often the case, the stasis is regional through localized enteroptoses, he recommends a **Curtis belt** and **liquid paraffin** as a lubricant to facilitate the passage of the intestinal content. This is especially indicated when there is angulation of the bowel at various points at which it is fixed. Careful **dieting**, including abstention from meats where spasm underlies the condition, antacids, such as **sodium bicarbonate** or **magnesium oxide**, where hyperacidity exists, and the **recumbent posture** at stated intervals during the day, have been found by him often to afford complete relief.

An important feature in my own cases, excepting those due to spasm, in which oil should be used (*vide infra*), is the use of **high positional irrigation**—not the obsolete “high enema”, since the insertion of a tube high up in the rectum, etc., has been shown by our Associate Editors, Pro-

fessors Brooker Mills and Bird, to be based on the fallacious idea that it will follow the course of the intestine, whereas in reality it coils within the rectum assuming the shape of a pretzel if enough of the tube is inserted—but by positional direction of the fluid used. Thus 2 pints (1000 c.c.) of water at 105°F. are injected while the patient is in the knee chest position; after remaining in the same attitude 5 minutes, he then gets on his right side thus causing the fluid to pass from the transverse colon to the descending colon and the cecum. The patient remains in this position about 20 minutes. This tends not only to straighten out any flexure, kink, etc., that may favor stagnation in the bowel, but also to liquefy and detach any fecal matter in the areas that are the seat of stasis. The use of X-ray examination, by determining the location and nature of these areas, makes it possible to adjust the positions to the needs of each case. The elimination of the fluid is often accompanied by considerable retained matter. **Cold enemas** are advocated by some. Large daily enemas of any kind are to be condemned: they cause, in fact, intestinal stasis in some cases by promoting paretic dilatation of the colon.

While the **Curtis belt** tends to remedy the enteroptosis which often accompanies intestinal stasis, particularly where insufficiency or relaxation of the abdominal muscles occurs in the aged, the obese, or the physically inactive, or follows frequent pregnancies, faulty posture, etc., **physical exercise** to enhance metabolic activity, out-of-door games, etc., **massage** of the abdominal walls, carefully regulated **gymnastics**, and

external hydrotherapy help greatly the curative process itself, particularly if the patient acquires the habit of attending to his toilet duties at a fixed time each day. Cathartic drugs should be avoided. Deficient sigmoid or rectal contractility is often aided by an enema, 4 ounces (120 c.c.) of **warm olive oil** or **liquid petrolatum** retained over night, the patient wearing a pad.

Feiner's oil cure, which consists of injecting into the rectum 250 to 500 c.c. ($\frac{1}{2}$ to 1 pint) of olive oil is advocated. Pure cottonseed oil yields equal benefit. The oil should be retained over-night, if possible. The injections are continued several months, at first daily, later every other day, and finally twice a week. They are useful both in spastic and atonic constipation. Where there is putrefaction the **Bulgarian bacillus** in liquid or tablet form may be prescribed. Its efficacy is enhanced by a **diet** preponderantly **carbohydrate**, with restriction of proteins. Poorly nourished patients should be well fed by **forced feeding** if necessary. **Cold water**, **half baths**, and the **Scotch douche** on the **abdomen**, with **rubbing** and **slapping**, are valuable; likewise **respiratory gymnastics** several times a day and **dry rubbing** of the skin with rough towels. **Massage** will strengthen the abdominal muscles, and **bandaging the abdomen** acts beneficially. All the patients need **iron**, but the sovereign remedy is **atropine** or **belladonna**. In the *atonic type*, requiring a different treatment, the **diet** should be bulky, with **agar** and **fruits** and **vegetables** rich in cellulose. **Petroleum jelly** of the best quality seems to act better than Russian mineral oil. C. D. Aaron (Buffalo Med. Jour., Aug., 1916).

When none of these measures succeed, surgery may be resorted to. Each case must then be studied individually, the location and character

of the ptosis being ascertained radiographically as far as possible before the operation to facilitate its identification when the abdomen has been opened. The operation should restore the physiological action of the bowel and its complete emptying, relieve back pressure and reflux into the ileum, avoiding any tissue destruction that may compromise its functions. While formerly such radical operations as excision of the cecum or resection of the transverse colon, the sigmoid, colectomy, and short circuiting operations were advocated, the tendency has been increasingly to use simpler operations.

In the year 1914 the writer operated to correct intestinal stasis in 36 cases, with 32 recoveries and 4 deaths. Only a small percentage of stasis cases need be surgically considered, viz., those in whom there is a possibility of overcoming it by removing tumors pressing on the intestine, or by correcting uterine displacement, obstruction due to bands, adhesions, or marked kinking, strictures following ulcer, annular carcinoma, or occasionally large papillomata, fibromata, or lipomata. If the obstruction cannot thus be relieved, short circuiting must be resorted to, and if the colon is dilated and permanently out of commission, at least the cecum and ascending colon should be removed; in severe cases one may have to remove the entire colon down to the sigmoid. A. J. Ochsner (Surg., Gynec. and Obstet., Jan., 1916).

The number of cases definitely cured of ileac stasis by repair of the ileocecal valve and removal of mechanical hindrances in the distal colon is now so considerable that the writer holds that the lesions mentioned are the true cause of ileac stasis rather than Lane's kink. When surgical interference becomes necessary the procedure indicated is the simple one of repair of the valve rather than the serious and mutilating

operation of short circuiting or of colectomy, except in cases in which the existence of obstructive lesions can be proved. Kellogg (Annals of Surg., Jan., 1918).

The surgery of chronic intestinal stasis cannot be standardized; in each case the patient must be made the subject of separate study and treatment designed to eliminate the causes. Thus anal fissure or irritable rectal ulcer will cause obstruction through the production of a hypertrophic and spasmodic sphincter muscle. Excision of the ulcer and superficial division of the sphincter will cure the condition. Fibrotic Houston's valves may also produce obstruction, and this can be relieved promptly by division of the valves through the application of a spring clip. Spastic enterostasis is usually due to some local inflammation or to reflex irritation, and removal of the inflammatory process, such as the appendix, or cure of putrefaction by medical means will cure the spastic condition. General enteroptosis is another frequent cause of intestinal stasis and can be much benefited by the performance of relatively simple operations for the replacement and fixation of the dilated and prolapsed portions of the gastrointestinal tract. Many cases of stasis are found to be due to peritoneal bands and omental adhesions, and the removal or section of these often cures the patient. Ileosigmoidostomy should be abandoned, for it violates the cardinal surgical principle of leaving the entire colon open above the stoma. Total colectomy should also be given up on account of its danger. On the other hand, **cecosigmoidostomy** may be employed in certain obstinate cases with good results in about two-thirds of the operations. F. C. Yeomans (N. Y. State Jour. of Med., Sept., 1918).

Operative interference is indicated in cases in which gastroduodenal distension is due to a damming back of the ileal contents by the pressure exerted by a "controlling appendix" or by an "ileal kink." The degree of in-

terference can be determined by the appearance of the patient, the history of the case, the pain elicited on pressure on the inflamed and hypertrophied end of the ileum, and the X-ray findings. Removal of the anchored appendix or the freeing of the ileal kink is usually sufficient to liberate the duodeno-jejunal junction from the strain. It is well to remember that the membrane which produces the ileal kink when well developed appears to contain lymphatics which drain the most infected portion of the ileum. Therefore, after the acquired band has been carefully separated from the mesentery and the torn peritoneal edges placed in accurate apposition, a drainage tube should be left in for two or three days, a precaution which may save the patient's life. It must be remembered that the kink tends to reform if the factors which produce it remain in action. **Colectomy** is indicated in such conditions as extreme constipation in which an evacuation can be obtained only at intervals and with great difficulty and pain; rapid and progressive wasting; mental depression which may result in attempted suicide; total inability to lead an active life; distressing absence of sexual desire; progressive degenerative changes in the breasts of those with marked family history of cancer; toxic changes in the heart and circulation, and all secondary conditions such as rheumatoid arthritis, Raynaud's disease, Still's disease, many forms of tubercle, Bright's disease, Addison's disease. In these and many other conditions, colectomy offers the only hope of cure. The writer points out that by colectomy, he means the *complete* removal of the large bowel with exception of a sufficient length of the pelvic colon to establish continuity. Removal of the cecum, ascending and part of the transverse colon, is rarely useful. Sir W. Arbuthnot Lane (Lancet, Mar. 1, 1919).

Marked thirst is usually complained of some time after the operation,

particularly after removal of any part of the colon, owing to reduction of the absorption surface. This symptom gradually disappears, however, the remaining structures assuming the functions of the segment removed.

HIRSCHSPRUNG'S DISEASE OR CONGENITAL MEGACOLON.

DEFINITION.—This is a congenital form of intestinal stasis in which a part or rarely the whole of the colon is markedly dilated, generally with hypertrophy of the bowel wall and elongation of the gut affected.

SYMPTOMS.—Constipation is noticed, as a rule, in early infancy, even the meconium being passed only with difficulty. Fecal tumors, palpable through the abdominal wall or by rectum, soon form, and are not removable by cathartics. Later the accumulations may be such as to cause marked distention of the abdomen, and visible peristalsis may be observed. Bowel movements may occur only at long intervals. In older children a valvular fold of the mucus membrane may be found upon rectal examination. Where the thoracic viscera are pressed upward by the fecal mass, the respiration may be purely costal and the heart action enfeebled; reabsorption of toxic material may also take part in the latter effect. Emaciation is a natural accompaniment, and apathy, unconsciousness, twitchings, tetany, and convulsions may be met with as toxic nervous symptoms.

Disturbance of the kidneys may occur from pressure on the ureters, and the superficial veins of the abdomen may be found dilated, and the legs edematous. Vomiting and pain

are only occasional symptoms. Exertion, straining, vomiting, or operative intervention may cause sudden death from collapse, owing to the weakened condition of the heart, or death may occur from septic colitis or bowel perforation and peritonitis.

Case of Hirschsprung's disease in a girl, aged 6 years, brought to the hospital in a condition of shock. She had been constipated for 5 years and had vomited for 24 hours. The patient was cyanosed, the eyes staring, the temperature 97.5° F. and the pulse 120. The abdomen was distended, and there was a constant involuntary discharge of feces. The thirst was intense. Colonic irrigations of physiologic sodium chloride solution were given with stimulation, heat, etc. The blood was viscid and not absorbed by Tallqvist paper. The child died 11 hours after admission. Secondary calcification of the lower part of the sigmoid and the upper part of the rectum were found. W. L. Carr (Trans. Amer. Pediat. Soc.; Jour. Amer. Med. Assoc., July 27, 1918).

DIAGNOSIS.—This is based upon the symptomatology of the disorder and an X-ray examination.

PATHOLOGY.—Usually the sigmoid is chiefly or exclusively involved; its circumference may attain 50 to 70 centimeters. At times enlargement of other segments, *e.g.*, the cecum and transverse colon, coexists, with the intervening segments quite normal. In the thickening of the bowel wall, the circular muscle layer is more hypertrophied than the longitudinal. Externally the affected gut presents a smooth appearance, the sacculations, *teniæ coli*, and sometimes the epiploic appendages having disappeared. Kinking of the bowel, commonly at the junction of the sigmoid and rectum, is believed

to occur as a secondary change in a majority of the cases, the result being a valve-like fold which accentuates the obstruction and its symptoms.

A valve formation in the bowel is the primary factor in certain cases of megacolon. The writer deems the term megacolon congenitum a misnomer. In a case developing at the age of 44, cured by sigmoid resection, there was a valve-like formation, but the flexure probably had been naturally large, and prolonged constipation had stretched it. Such cases are not true Hirschsprung's disease. R. J. de Jong (Neder. Tijds. v. Geneeskunde, May 20, 1916).

At times obstructions are alleviated by nature, by diet, and by enemata, or they may go on to obstruction, be operated on and pass away. The prognosis is very bad if one makes an artificial anus. Some cases with this condition proceed to adolescence. It may be rapidly fatal or go along quite normally for a time. Henry Koplik (Trans. Amer. Pediat. Soc.; Med. Rec., Dec. 14, 1918).

The name Hirschsprung's disease is applied to a stage in a common condition. When this condition is dignified by the term, it is in a late stage of the disease. The time to treat it is before the dilatation occurs. There are many cases of Hirschsprung's disease walking about today, some will reach the stage of dilatation when they will be recognized and others will not. F. B. Talbot (Trans. Amer. Pediat. Soc.; Med. Rec., Dec. 14, 1918).

The writer has reported 20 cases of elongated sigmoid. These cases are fairly usual and the name Hirschsprung's disease should be dropped. They are identical with the elongated sigmoids that fold upon themselves and become sacculated and dilated and are accompanied by saccululation and later constriction. The condition is one that is very frequent and it is the severe cases that go on to the formation of gross lesions. C. G.

Kerley (Trans. Amer. Pediat. Soc.; Med. Rec., Dec. 14, 1918).

TREATMENT.—Non-operative treatment, alone appropriate in early infancy, consists in evacuating the bowel as well as practicable with **enemas**, and in continuing nursing as long as circumstances permit. Permanent drainage of the rectum by a **rectal tube** has been advised. Operative treatment is alone satisfactory. In greatly weakened subjects, preliminary institution of an **artificial anus** is frequently advisable to permit of unloading the bowel and improving the general condition. **Re-section** of the affected portion of bowel is the best operative procedure. Any **kink** below the enlargement must likewise be **eliminated**.

Of 151 cases treated by internal measures alone, only 38 were cured and 14 improved; 79 died, and the outcome was unknown in 14 cases. Internal measures succeed best in children, and should be given a prolonged trial first. **Sedatives** should be used for spasm in any part of the bowel. The **sphincter** in spasm should be bloodlessly **stretched**. **Massage**, **electricity**, and **diet**, with **bowel irrigations**, will often cure early cases. Of 69 children operated on, 32 were cured and 26 died. **Colopexy** or **re-section** at 2 sittings gave the best results. Schneiderhöhn (Zeit. f. Kinderheilk, xii, Nu. 4-5, 1915).

Stress is laid by the writer on a group of cases which have recurring attacks of pain, fever, vomiting, and acute obstructive signs, despite every effort to prevent them. In other cases, constipation will often yield to careful treatment, especially **saline enemata**. **Massage** helps the abdominal wall, and mechanically moves along fecal material, especially with a drainage tube in the rectum. The **diet** should consist of coarse breads and cereals, green vegetables, and agar-agar. **Much water** should be

taken. **Russian oil** is very helpful. R. M. Smith (Lancet-Clinic, Mar. 25, 1916).

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INTRAVENOUS INJECTION TECHNIQUE. See INFUSIONS, SALINE.

INTUBATION OF THE LARYNX.—Medical science is indebted to Bouchut, of Paris, for the idea of relieving stenosis of the larynx by means of a tube introduced by way of the mouth; but to the late Joseph O'Dwyer, of New York, belongs the honor of reviving the operation from buried forgetfulness, and by his ingenuity of so modifying the instruments as to make them of practical utility.

The relief of laryngeal stenosis by means of catheters introduced into the trachea through the larynx, the use of the short round tube as employed by Bouchut (Fig. 1), and O'Dwyer's early experiments and the gradual development of the instruments (Figs. 2, 3, 4, 5, 6, and 7) are all matters of history which have been fully recorded in medical literature.

Intubation of the larynx is a difficult operation. It certainly requires the maximum amount of manual dexterity if it is to be performed with gentleness and celerity. One cannot become expert without considerable practical experience. Theoretical knowledge is important, but I would emphasize the necessity of a thorough and careful training by practice upon the cadaver. Unless the operation is quickly and skillfully done, it becomes repulsive and brutal. The difficult technique has doubtless had much to do with the opposition it has met in the past.

INDICATIONS.—Are all cases of alarming dyspnea to be treated by intubation? Most decidedly not. In case of foreign bodies so imbedded in the larynx as to produce difficult respiration the performance of intubation would obviously be a fatal mistake. Cases of pharyngeal abscess located low down, causing more or less difficulty in breathing, or cases of

the arytenoid cartilages and of the epiglottis is so great that the head of the tube in the larynx is overlapped; hence little relief is experienced. The larynx here requires rest, which it cannot obtain with a large, heavy tube *in situ*.

When called to a case of suffocation, before hastily resorting to intubation one should make a correct



Fig. 1.



Fig. 2.



Fig. 3.



Fig. 4.



Fig. 5.



Fig. 6.



Fig. 7.

Gradual development of intubation instruments.

retroesophageal abscess, had best, for obvious reasons, be treated otherwise. In many cases there is marked dyspnea from great enlargement of the tonsils and uvula, associated with nasal obstruction, with little or no involvement of the larynx. Intubation would be useless and uncalled for in these cases. Edema of the larynx may give rise to great and even fatal dyspnea. The majority of such cases are better treated by tracheotomy. In most of these cases the swelling of

diagnosis and exclude the cases in which this operation is clearly contraindicated. This matter of differential diagnosis is most important, and a patient's life may depend quite as much upon the diagnostic skill of the physician as upon his ability to do the operation when indicated. The special field and usefulness of intubation is in cases of diphtheritic or membranous obstruction of the larynx, in laryngeal growths in children, and in cicatricial stenosis in the adult.

It is unnecessary in this connection to review the literature of intubation in cases of papilloma in children or of cicatricial stenosis in the adult. It is a legitimate and often successful procedure in both conditions.

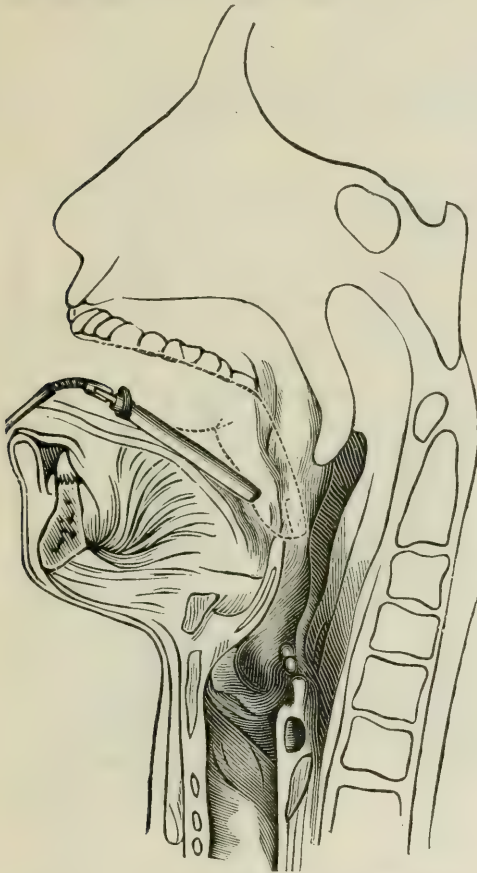


Fig. 8.—Course of the tube from the mouth to the laryngeal cavity.

INTUBATION IN DIPHTHERIA.—In the great majority of cases the operation will be called for to relieve the impending suffocation in diphtheritic or so-called membranous croup. Serum treatment has greatly diminished the percentage of intubations, as antitoxin causes the most serious symptoms rapidly to disappear. The main use of intubation at

present, therefore, is *to assist in tiding the patient over momentary peril*. The ratio of cases requiring intubation in hospital practice varies from about 10 to 30 per cent. of the total number. Inasmuch as, properly carried out, the operation in no wise compromises the case or adds to its danger, but gives comfort, relieves suffering, and prevents exhaustion, there seems to be no valid reason why it should be postponed after certain well-marked symptoms have occurred.

When the voice becomes toneless and whispering, and the cough is suppressed; when, in addition, the dyspnea becomes urgent, and the loud stridor of croup is heard both during inspiration and expiration; when there is marked recession at the base of the sternum and above the clavicles; when the pulse begins to fail or becomes intermittent, and when all these symptoms cannot be relieved by emetics, it is certainly time to intubate.

One can save the majority of cases if a tube is passed as soon as signs of laryngeal obstruction are sufficiently severe to cause indrawing of the supraclavicular and epigastric regions; but if one waits until edema of the lungs and bronchopneumonia have set in, the results are not any better than those of tracheotomy. J. F. Couch (Austral. Med. Gaz., June 20, 1907).

While one is not justified in waiting longer after these symptoms have appeared, it is even better when possible to operate earlier. When the diagnosis is positive, as indicated by the voice and cough, beginning dyspnea, the bacteriological examination, and gradually increasing distress in spite of treatment, one should not wait until the condition becomes alarming. In infants and in young and feeble

subjects dyspnea insufficient to give rise to marked cyanosis or alarming symptoms of suffocation may nevertheless be sufficient to cause dangerous or even fatal exhaustion. In these cases it is the physician's duty to operate earlier than when the patients are older, more rugged, and better able to stand the exhaustion caused by difficult respiration.

The temporary cyanosis which comes and goes with the paroxysmal dyspnea of the second stage of croup is of no particular significance. Children seldom remain long in one position when suffering severely from want of breath, and continued restlessness, if consciousness be unimpaired, is therefore an important indication that it is time to afford relief (O'Dwyer).

TECHNIQUE.—Preliminary Practice.—Preliminary practice upon the adult cadaver is of but little help in acquiring the operative technique for children. The adult larynx, in the cadaver, is almost beyond the reach of the finger; the epiglottis is prominent, while the cavity of the larynx is large and easily determined. In young children, however, the epiglottis is small, while the rima glottidis feels to the touch as a mere slit or depression. By referring to Fig. 8 it will be seen that, if the epiglottis is drawn forward with the finger and the tube is passed in the median line with its point hugging the anterior wall, it must necessarily pass into the larynx. It is important to follow precisely the median line and to hug the anterior wall with the point of the tube.

Some operators prefer to perform the operation in the adult by the aid of the laryngeal mirror. The patient holds the tongue (with a napkin or

soft towel between the thumb and forefinger of the right hand) well drawn out, while the operator, sitting in front and aided by reflected light from a mirror on the forehead and by the laryngeal mirror, guides the tube over the epiglottis and engages its

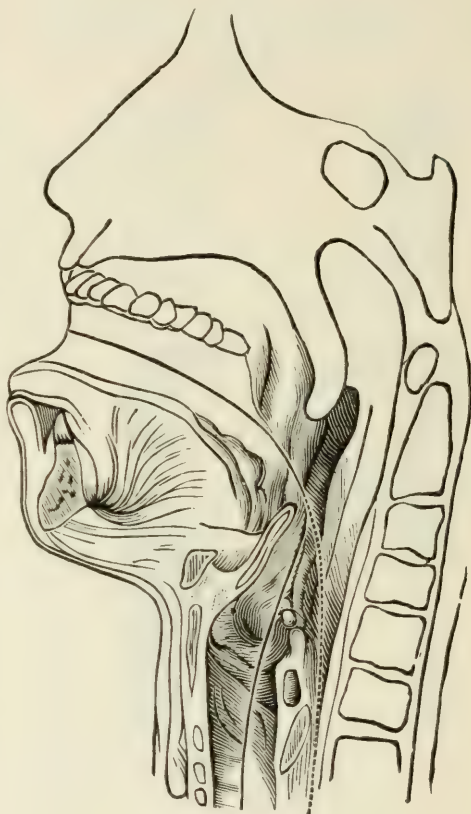


Fig. 9.

point in the cavity of the larynx. Quickly dropping the laryngeal mirror from the left hand, he then passes the forefinger down upon the head of the tube and crowds it into position. One accustomed to laryngeal work will perform the operation in this manner very readily, but the procedure is practically impossible for one not familiar with laryngeal instruments and their use.

Intubation in children by this method is impracticable. The patient must be properly held before a good light. The base of the tongue is held down with a tongue-depressor and, as the epiglottis rises to view, the point of the tube is directed into the larynx,

ferred; but it may be employed by those who do not possess or who cannot acquire the manual dexterity to perform the operation with the assistance of the tactile sense alone, *i.e.*, unaided by the eye.

The ideal operation should be con-

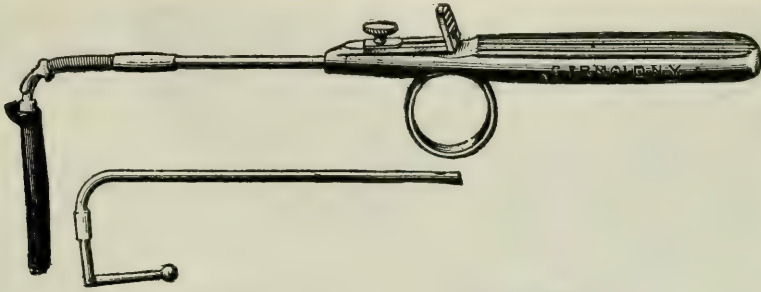


Fig. 10.—Introducer with tube and detached obturator.

passing immediately behind the epiglottis. The tube is then pressed down into position with the forefinger of the left hand as the tube is released from its introducer. As soon as the point of the tube passes over the epiglottis, the hand holding the intro-

duced through the sense of touch entirely. One should handle the instruments frequently; the sliding spring of the introducer, shown in the cut, should be moved by the thumb and not by the forefinger. The extractor should be held in the manner indi-

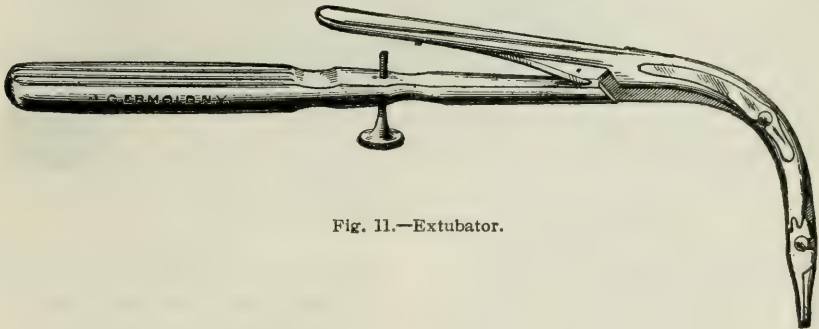


Fig. 11.—Extubator.

ducer must be quickly elevated, keeping the point of the tube stationary until the turn is made, in order that the tube may pass down at an acute angle. Otherwise the tube will invariably slide over into the esophagus. Figure 9 shows how such a misdirection can be given the tube. This method is not that to be pre-

icated by the second figure. By frequently introducing the tube into the closed hand of another person, holding the introducer in the right hand, detaching the tube and pressing it down with the forefinger of the left hand in the exact manner as when introduced into the larynx, slight practical experience can be gained. One

should become so familiar with the instruments that the various steps of the operation can be carried out, so to say, automatically.

As the extraction of the tube is even more difficult than its introduction, it is important also to practice

when the end of the tube reaches the larynx, and before it becomes engaged, spasm of the larynx occurs. In such a case it is best, instead of using force, simply to wait a few seconds, holding the tube in position. The patient will then endeavor to



Fig. 12.—Intubation. Second step in operation: Handle of introducer elevated, the tube sinking into larynx as the handle of introducer is elevated. (Fischer.)

extracting it from the closed hand of another. Introducing and extracting the tube from the larynx of a small dog under an anesthetic will frequently be of great help in acquiring dexterity.

The instruments should be held lightly. Little or no force should be used, no anesthetic is necessary, and the operation should not require a longer time than from five to ten seconds. It occasionally happens that

breathe, the spasm will relax, and the tube will drop into position.

The operator is exposed to infection through injury, previously broken skin, and explosive cough. To avoid the first, a piece of adhesive strip may be placed over the second or third joint of the left index finger, reaching well up the back of the hand. This will obviate injury from contact with teeth in reaching down the throat to raise the epiglottis. Infection through previously broken skin—cuts, scratches, etc., probably forgot-

ten—may be avoided by placing the hand in ammonia water. Such injuries will be forcibly brought to the operator's attention and collodion may be applied or a finger cot worn. To protect the eyes, ordinary spectacles may be worn. G. F. Cott (Laryngoscope, Feb., 1905).

In performing the operation the physician should first select a tube appropriate for the age of the patient, as indicated by a scale that accompanies every set of instruments. The tube should then be threaded with silk or linen thread, making a loop about 14 inches in length. The obturator fitting the tube to be used (Fig. 7) should then be screwed upon the introducer if the O'Dwyer instruments are used, and the tube attached. It is now ready for use, and should be placed upon the table within easy reach. The patient is frequently held upright in the lap of the nurse, supported closely against the left chest with the head resting on the shoulder. Another plan, in many instances more convenient, especially where there are no trained assistants, is to wrap the child firmly, all but the head, in a blanket, and place him flat on his back on a table ("dorsal method"). The nurse, if one be available, has merely to hold the child's head still and keep the gag in place (Fig. 12).

The modern method of intubation is the dorsal method, which is easiest in an emergency, because the physician can intubate without many assistants. The introducer should always be held lightly between the thumb and forefinger. Upon repeated forcible attempts at intubation one may enter the ventricles of the larynx, producing a false passage. In such event it is wiser to resort to tracheotomy than to run the danger incident to exhaustion.

Strychnine should be very liberally

prescribed from the beginning of the illness. A child several years old can frequently take $\frac{1}{50}$ grain (0.0013 Gm.) three times a day and oftener to advantage.

Recurring laryngeal stenosis after intubation is usually caused by forcibly pushing the tube into an edematous or infiltrated mucous membrane. The only safeguard in preventing excessive mechanical injury is to introduce a tube of small caliber.

It is a wise rule to remove the tube every five days. Where a tube must be introduced more than twice, the writer adopts the following plan, mentioned by O'Dwyer: Taking a rubber tube, immerse it in a **solution of hot gelatin** containing 25 per cent. of **powdered alum**; introduce the tube with this covering of alum gelatin. The author has also had success with 20 per cent. solution of **ichthyol gelatin**. In the same manner a film consisting of **hot paraffin** and **iodoform** or **europhen**, 3 per cent., was applied in another case with very good results. This intralaryngeal medication of the ulcer by means of the intubation tube proved of value in severe cases.

Where an unskilled operator must intubate, a hypodermic injection of $\frac{1}{400}$ grain (0.00065 Gm.) **strychnine** or $\frac{1}{2}$ grain (0.032 Gm.) **caffeine sodium benzoate** may be given prior to the operation. It is also wise to have a **mustard foot bath** ready in case of collapse. If the circulation does not improve after this foot bath, given at 100° F., a **hot saline colon flushing** at 115° to 120° F. may be administered. Louis Fischer (N. Y. Med. Jour., Aug. 1, 1908).

If the older, upright, position be employed, the nurse should sit upright in a straight-backed chair and the patient be held firmly and not allowed to slide down. The forearms of the child should be crossed in front and the nurse should grasp the wrists, the left wrist with her right hand and the right wrist with her left

hand. The gag is then introduced in the left angle of the mouth well back between the teeth and widely opened. The operator, standing in front, then quickly seizes the introducer with tube attached, hooks the loop or bridle over the little finger of the left hand, and introduces the index finger of the same hand, closely followed by the tube. He raises the epiglottis forward with the index finger (Fig. 8) and guides the end of the tube gently over it, when, by making an abrupt turn, he will pass the tube into the larynx if he has been careful to keep in the median line; or he may pass the index finger over the epiglottis and upon the arytenoid cartilages and guide the end of the tube into the larynx.

A method advocated by some is to feel for the small opening or depression just back of the epiglottis with the finger and guide the end of the tube into it. In any case the end of the tube should pass under the tip of the finger, not over it or by the side of it, but directly under it. The moment the end of the tube engages the larynx, the right hand, holding the introducer, should be quickly elevated, allowing the tube to pass down at a right angle. Simultaneously the tube is loosened from the introducer by pressing forward the slide with the thumb. The index finger of the left hand, which has acted as guide, is placed upon the head of the tube and gently presses it down into position as the introducer is removed. It is important to bear in mind the necessity of hugging the anterior wall with the end of the tube as it is introduced. In order to do this, it should follow a gentle curve, until it has passed over the epiglottis, and remain stationary

for an instant as far as downward progress is concerned, while the handle is quickly elevated. The dark line in Fig. 13 represents the curve that should be followed by the end of the tube while it is being introduced. This sudden turn constitutes one of the salient points of the operation, for if the curve be continued as indicated by the dotted line the tube will invariably pass into the esophagus.

A prolonged attempt at introducing the tube should be avoided. Many brief trials characterized by gentleness will do much less harm. If during the first attempt the tube passes into the esophagus, the instrument and the finger should be removed from the throat and the patient allowed to recover his breath for a moment. A new trial is then made. Entrance of the tube into the larynx is indicated by violent coughing and by easy respiration, if the tube is not blocked by membrane below it.

To ascertain whether the tube is in position the child, sitting upright, is allowed to drink a small quantity of water from a glass; if the tube is in the larynx violent coughing will result. If it is in the esophagus there will be no violent coughing, no relief from the threatening suffocation, and there will also be a gradual shortening of the loop as the tube gravitates toward the stomach.

If the operator is quite certain that the tube has entered the larynx, the gag should be removed and the loop placed backward over the ear. While doing this, the hands of the patient should be held firmly by the nurse; otherwise the child will grasp the thread, pull out the tube, and the procedure will have to be repeated. The

operator should wait a few minutes to make sure that the tube is in position, and to allow the cough to expel the mucus and softened membrane. He should then replace the gag, cut the loop near the mouth, and introduce the index finger of the left hand until it reaches the head of the tube. This is held down while the thread is removed by pulling on one end of the loop.

Intubation should be performed with the child lying in bed, to disturb as little as possible the absolute rest which is essential in diphtheria. With practice it will be possible to avoid opening the gag very widely while introducing the tube. Opening the gag often causes an increase in the dyspnea. It should always be closed or removed between attempts to introduce the tube. The tubular character of the violent respiration following successful intubation is unmistakable. In its absence the tube may be pulled at once from the esophagus, into which it has certainly passed. The author uses tubes suitable for children from 6 months to 2 years larger than specified in the O'Dwyer scale. The thread attached to the tube should be retained as long as the tube is in the larynx. If much coughing follows, the milk given should be thickened with arrowroot. Fairbank (*Lancet*, June 20, 1903).

If, in introducing the tube, membrane is crowded down ahead of it and respiration is difficult or impossible as a consequence, the patient should be encouraged to cough violently. As he does this the tube should be quickly jerked by means of the thread still attached, or the tube may be entirely removed by extubation. Frequently a large mass of membrane will be expelled. If this does not occur, stimulants and water should be given and violent coughing encouraged.

It will occasionally happen that in spite of all efforts a patient is unable to expel the offending and obstructing membrane. In such a case it is necessary to employ a long pair of tracheal forceps and, as the child coughs, endeavor to grasp the membrane and remove it. If one is still unsuccessful, the last resort is to perform tracheotomy and extract the membrane. This, however, is rarely necessary. Of 498 intubation cases in v. Bokay's series, an immediate tracheotomy became necessary in $3\frac{1}{2}$ per cent. Tracheotomy failed to relieve the asphyxia in only 2 of these cases, and these patients died from the pushing down of false membrane.

After intubation, the loop of thread passed through the tube may be cut at the angle of the mouth and removed, while the left forefinger guards against withdrawal of the tube. Left on, the thread annoys the child, provokes coughing and gagging and in consequence autoextubation, interferes with nourishment, and produces ulcers at the corner of the mouth. Having removed at autopsies larynges bearing decubital ulcers whose position on the head of the larynx plainly indicated the responsibility of the string, it is the author's rule, assured by a single inspiration of the proper position and patency of the tube, immediately to withdraw the string while the gag is yet in place, irrespective of the child's age.

Pushing down membrane in advance of the tube is likely to happen to any one at any time, particularly in late cases of diphtheria and cases that have required repeated intubation, and those in which large doses of antitoxin had been administered, favoring the exfoliation of the membrane. Fatal results, however, are infrequent. In over 800 intubations the author did not have a single fatality from this cause. With its prompt recognition the danger is met

by immediate withdrawal of the tube by its string. With the head already lowered (in the dorsal method), the loosened membrane is driven out by the expulsive cough, and with it probably all further need of a reintroduction removed.

There is occasional difficulty in hooking forward an epiglottis folded upon itself or shortened by its inherent power of contraction; gentle traction on the base of the tongue with the armed obturator has often successfully served the author in such cases. Faulty manipulation completely occluding the air passages may induce a laryngeal spasm; upon withdrawing the obturator as soon as the end of the tube engages in the larynx and allowing air to enter, this spasm will relax. Should it, however, refuse to yield, it is only necessary to steady the tube by gentle digital pressure on its head until the next inspiratory effort invites its gliding into its bed.

Aiming to minimize the risk of pressure sores, the author ordinarily removes the tube in three or four days, particularly when gradual disappearance of visible exudate and general healthier aspect of tonsils and pharynx encourage the trial. Vulcanized tubes are longer tolerated than the metallic, which require more frequent cleansing of their irritating lime-salt deposits.

When an operator, in the effort to extubate, has pushed the tube beyond digital reach and is confronted by alarming symptoms of a supratubal edema external manipulation will frequently succeed in stripping the tube to within reach of the extractor and thus avoid tracheotomy. Lee Kahn (*Amer. Pract. and News*, April, 1911).

If the child is not too far from the physician in charge and an intelligent person can be secured and taught how to remove the tube instantly in case it becomes occluded, the child may remain in the home, but, as a general rule, swift removal to an institution is safer. A stay of three to five days is generally all that is required. The string from the

tube can be given sufficient slack in the mouth, then pulled upon the child's cheek, and there fastened with a bit of adhesive plaster. Under no circumstances should the string be removed till the tube comes with it. The child in a few hours becomes accustomed to the string as well as the tube and does not care for it. In case the tube becomes suddenly stopped up by membrane or thick mucus, the most skilled operator cannot remove the tube quick enough to prevent strangulation, whereas if the string is left in, the nurse can instantly remove it. The child must be kept continually bound in a sheet so as to prevent its getting hold of the

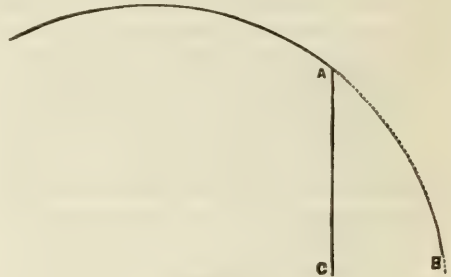


Fig. 13.

string. The resulting inconvenience is more than outweighed in the safety which it promises. The nurse should three or four times a day introduce her finger and feel for the tube in the larynx. It should barely be felt, and in case it be prominent between the vocal cords she should gently push it down.

As a rule, the tube should not be taken out for twenty-four hours after the symptoms have vanished. If it does not have to be replaced in four hours, it can usually be dispensed with. Hoarseness often remains for several weeks after intubation. J. J. Waller (*So. Med. Jour.*, Oct., 1912).

After the tube has been successfully introduced the patient experiences entire relief. The change in the appearance of the patient is not only immediate, but remarkable. The loud stridor, sometimes heard all over the

house; the projecting eyeballs, the livid features, the cyanosis, the clutching at the throat, the piteous begging in a whispering voice for help, cease as if by magic. The patient lies pale and quiet. The loud stridor is replaced by almost noiseless respiration, and the patient falls into quiet, refreshing slumber.



Fig. 14.—Casselberry method of feeding. (Fischer.)

AFTER-TREATMENT OF INTUBATED CASES.—Rest and nutrition are now important. In the early days of intubation, the question of feeding was beset with many difficulties, but later these obstacles were largely overcome. It was found by Carey and Casselberry, of Chicago, while jointly treating a case, that if the patient was placed in the recumbent position, with the head slightly lower than the shoulders, swallowing could be effected with little difficulty. This discovery marked a great ad-

vance in the successful management of these cases, and added not a little to the success of the operation and to the comfort of the little sufferers.

The mechanism is simple enough: The intubation tube being inclined, with the proximal end lower than the distal, the fluid cannot drop into it. The patient should be placed on a pillow with the head extending slightly over it, either on the back or the side, preferably the side; the pillow is moved over the side of the bed and the head slightly depressed (Fig. 14). If the head is lowered too much the fluid will pass into the post-nasal space and nasal cavities, while if it is raised too much it will pass through the tube and into the lungs and cause violent coughing. A few trials will demonstrate the required position in each individual case. With a little patience and firmness a child should take an abundance of liquid nourishment without difficulty. The physician should himself attend personally to this matter until the attendants are so trained that they are fully capable. Hillis prefers to have the patient lie on the stomach, face down, as this gives him greater command over the constrictors.

It is best to give water and food from a spoon, although some children will prefer to draw it through a glass or rubber tube. The nourishment should be milk, beef-juice, or the various soups, although semisolids—as custards, ice-cream, and the like—may be allowed where there is repugnance for the more fluid foods. Milk is the most convenient and usually the best food that can be given in these cases, though Fischer states that in the older children he invariably administers articles such as

bread soaked in milk, junket, corn-starch or rice pudding, soft-boiled eggs, chicken jelly, etc. Where a breast-fed infant will not nurse, the milk can be obtained by means of a pump and administered with a spoon. If vomiting should occur in intubated cases, rectal alimentation may be availed of.

In feeding the intubated child a glass tube is desirable if the child can be taught to use it, and in most cases it can. If it is inclined to bite the tube a small piece of rubber tubing can be attached for the child's mouth. If the child can not or will not attempt to swallow, gavage is easily carried out. J. J. Waller (*So. Med. Jour.*, Oct., 1912).

Regarding the after-treatment, little need be said. **Antitoxin** should have been given at the very onset of the disease and should have been repeated. If not, it should now be given in large dosage and again repeated in twelve or sixteen hours. If there is a tendency of the membrane to extend downward, as indicated by quickened respiration and sometimes by râles or roughened or harsh respiratory sounds, then the antitoxin should be crowded to the limit.

OBSTRUCTION OF TUBE.—

The attendants should be instructed in case of emergency, if obstruction occurs suddenly, to hold the child with the head down, shaking him while another suddenly and sharply strikes the patient a smart blow upon the chest and back.

In case total obstruction occurs the child will die in a few moments unless the tube can be expelled. Happily, these emergencies do not frequently occur. If everything goes smoothly, the patient is taking nourishment well, and there has occurred no evidence

of obstruction, it is my custom to remove the tube on the fourth or fifth day. It will very seldom happen that the tube will be necessary for a longer time, providing the operation has been skillfully performed and no damage done to the pharynx. The shorter the time the tube is worn, the less likely is one to meet with paralysis of the vocal cords and other conditions that often require its long-continued use.

Obstruction of the tube taking place a variable time after its introduction is apparently rare (1 to 6 per cent., according to different writers). Expulsion of it is more frequent, and is the most serious objection to intubation not under constant supervision. Attacks of asphyxia may arise from food, mucus, or blood reaching the vestibule, the spasm of the muscles thus induced causing a very sudden danger. Extubation with the extubator is much more delicate and dangerous than intubation, and, since the need for removal of the tube may be urgent, the author recommends retention of the thread. F. Castelain (*L'Echo méd. du Nord*, No. 47, 1903).

In extracting the tube, the patient should be placed in the same position as when it is introduced. The gag should be placed as before and the index finger of the left hand introduced until it reaches the head of the tube. The extubator, the point of which should be guided into the tube, is held in the right hand, and should quickly follow the finger (Fig. 15). By pressing on the lever above the handle the jaws of the instrument are separated, thus holding the tube securely while it is removed.

The irritation from removal of an intubation tube sometimes causes laryngeal spasm, with excessive secretion of mucus, rendering it necessary to reintroduce the tube, which is often very difficult. The spasm and

mucous secretion can be obviated by administering a dose of **atropine sulphate** fifteen to twenty minutes before removal. The author never practises instrumental removal, finding it easier, quicker, and safer to remove the tube by exerting slight

given in water or in milk, every three hours. **Codeine**, $\frac{1}{10}$ to $\frac{1}{4}$ grain (0.006 to 0.016 Gm.), may be given on the evening before extubation, to insure rest to the nervous system. Louis Fischer (N. Y. Med. Jour., Aug. 1, 1908).

If the case is not one of mixed infection, all sprays and douches and applications to the throat can be abandoned. In case of *mixed infection*, if there is much offensive discharge from the nose and throat, a simple **non-irritating antiseptic solution** should be gently used in the nasal cavities with the douche or syringe and in the throat by means of the spray, **antitoxin** being given at the same time and the patient supported by **stimulants** and **nourishment**.

How long should the tube be allowed to remain in the larynx? This will depend entirely upon circumstances. If there is a considerable amount of membrane in the trachea it must necessarily come away; sometimes it softens down and is expelled through the tube in the form of mucus without difficulty, but not infrequently large flakes or patches become loosened and endanger the life of the patient by obstructing the tube. If a too tightly fitting tube has not been used it will frequently be expelled on the second or third day on account of obstructing membrane below it, and commonly it will not be necessary to replace it. It is always to be feared, however, that the tube may not be expelled when it becomes obstructed. Whenever there is evidence of partially detached membrane below the tube indicated by a flapping sound, a peculiar hoarseness of the cough, or by sudden and evident closure of tube during an expulsive

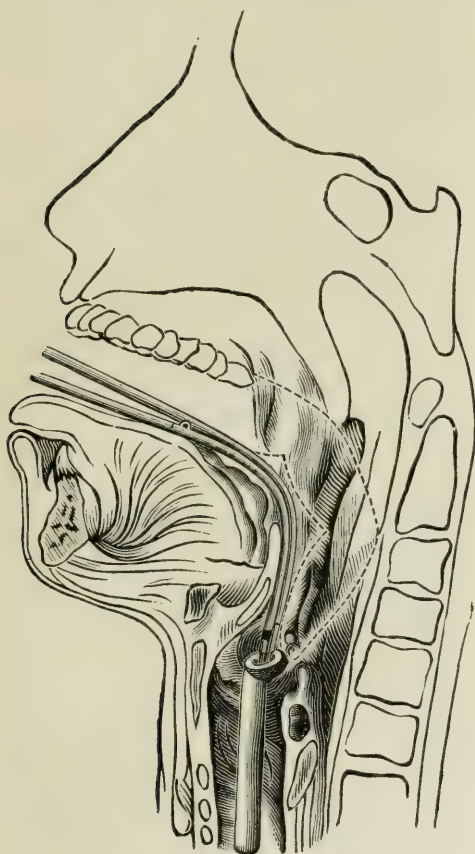


Fig. 15.

pressure backward and upward below the tube on the trachea. The patient then gags, when the tube can be easily grasped with forceps or fingers. Lewis (Va. Med. Semi-Monthly, March 27, 1908).

In extubation with recurring laryngeal stenosis, especially in a very nervous and fretful child, the author orders sedatives for twenty-four hours before the operation. From 5 to 10 grains (0.3 to 0.6 Gm.) of **sodium bromide**, according to age, may be

cough, one should at once extract the tube, whether it has been in one day, three days, or four days, or else remain constantly with the patient in order to extract the tube in case total obstruction occurs and the patient is unable to expel it.

In an average case the tube should be removed and replaced at the end of twenty-four hours, and again removed at the end of a further twelve hours and results awaited. If it has to be replaced it should again be removed at the end of twenty-four hours; if, yet again it has to be replaced, it should be left in forty-eight hours.

If immediate relief is not afforded by intubation, or if the child should grow worse, the tube should be removed. Severe ulceration of the larynx is uncommon; its signs are free bleeding from the larynx, rapid and repeated appearance of edema after removal of the tube, tenderness, and fever. If such a condition grows worse, tracheotomy should be performed at once. In the great majority of cases, however, secondary tracheotomy diminishes the child's prospects of recovery. Abscess formation in front of the larynx or the trachea calls for immediate tracheotomy. Fairbank (*Lancet*, June 20, 1903).

Trumpp found, in a case in which attempts at extraction had caused a small tube to sink farther down into the larynx, that pressure with the thumb on the trachea, just below the cricoid cartilage, where the end of the tube could be felt, caused cough, which forced the tube out. This method of expression never failed in his subsequent cases. The pressure may be made with both thumbs inward and directly upward. If strong pressure is exerted the tube may be forced entirely out of the mouth.

While it is the rule that the tube is

no longer necessary after the fourth or fifth day, and frequently not after the second or third, yet it sometimes occurs that it cannot be dispensed with for two, three, or six weeks, or even longer. After its removal the dyspnea returns, sometimes immediately, sometimes after a few hours, and occasionally after one or two days have passed.

It is always well to remain with the patient an hour after the removal of the tube or be within ready call in order to replace the tube in case of emergency. Cases of sudden death have occurred from returning dyspnea after the operation has left the patient in fancied security. As a rule, the dyspnea returns slowly; so that it is several hours before the patient is in an alarming condition. Occasionally it returns suddenly and almost immediately after the removal of the tube. Labored breathing and a sudden increase in the respiratory or pulse rate are the danger signals.

PROLONGED USE OF TUBE.—

A number of causes have been enumerated as rendering necessary the long-continued use of the tube. Principal among them may be mentioned the formation of diphtheritic exudate or its long persistence in the larynx and trachea; edema of the tissues; ulceration of the cricoid cartilage and consequent collapse of the thyroid cartilage; cicatricial contractions and exuberant granulations following ulcerations, and abduction paralysis.

According to Rogers and Köhl, the commonest cause of postdiphtheritic stenosis necessitating prolonged use of a tube is a hypertrophy of the subglottic tissues, with chronic inflammation. Neither this, however, nor the less frequently occurring ulceration,

followed by cicatricial tissue and contraction, is due directly to the intubation, except in rare, unavoidable instances. Rogers holds, moreover, that exuberant granulations do not occur with intubation, no matter how prolonged. Fischer thinks rachitic children are predisposed to laryngeal stenosis as a result of diphtheria.

O'Dwyer and many others have held, however, that some of the lesions observed are due to a too tightly fitting tube, to leaving the tube in too long, to poorly constructed instruments, and some to injuries resulting from unskilled operations. With the use of antitoxin, which enables the patient to dispense with the tube at an earlier date, and great skill acquired in performing the operation, these conditions would then, of course, less frequently arise.

An important point is that when the operator appreciates the fact that a tube is too large, as indicated by the force required to press it down into position, he should at once remove it and use a smaller one. The unduly large one might not only cause ulceration or paralysis from undue pressure, but, in case of obstruction below the tube, also give rise to exfoliation of membrane. There would, furthermore, be danger of sudden suffocation from the inability of the patient to expel the tube.

Since the tube, while in the larynx, moves with each swallow, cry, or even respiration of the patient unless it is of the proper shape and size, serious lesions in the larynx are apt to occur. Decubitus sores, as such injuries are called, are usually situated (1) on the anterior wall of the trachea below the cricoid, due to pressure of the lower end of the tube; (2) above the cricoid over the lateral and anterior surface of the larynx, due to pressure of the

retention swell, or (3) on the under surfaces of the epiglottis, due to pressure from the head of the tube. The most important of these is the decubitus above the cricoid laterally and in front, for here enter on both sides the recurrent laryngeal nerves and it is urged that it is pressure paralysis of the nerves which gives rise to the third group of cases, characterized by repeated coughing up of the tubes. Most of these injuries are due to the use of unskillful modifications of the O'Dwyer tube. When the vocal cords are paralyzed as a result of pressure on the nerves the tube loses one of its most important means of retention, for the cords do not form a constriction above the retention swell. H. W. E. Berg (*Med. Rec.*, Aug. 1, 1903).

In case there is long-continued necessity for the use of the tube—as occurs in about 1 per cent. of all intubated patients (Duel)—what can be done? After removing the tube on the fourth or fifth day, if the dyspnea returns, a smaller tube should be introduced instead of the one removed. This in turn should not remain longer than two days without being removed, providing it has not been previously expelled. If the dyspnea still returns, introduce a still smaller tube. The effort should now be to use the smallest tube that will be retained. This method, together with the free administration of **strychnine**, offers the greatest hope of promptly overcoming the difficulty (Waxham).

Since, in prolonged cases of intubation, autoextubation is common, and an element of danger is thus introduced when no experienced intubator is constantly on hand, many such cases are subjected to tracheotomy, for greater safety. After high tracheotomy, however, cicatricial bands are almost certain to form in the tra-

chea or lower portion of the larynx above the tracheotomy (Duel). It may, therefore, become necessary to dilate the involved canal by the insertion of progressively larger tubes, under anesthesia. Fischer advises that a large special tube, with the constriction below its neck only $\frac{1}{32}$ inch smaller than the retaining swell, be then left in undisturbed for at least six weeks. If a cure has not been accomplished at the end of this period, it can be replaced.

Prolonged intubation often gives rise to the formation of ulcers in the cricoid region, provoking edema below the glottis and laryngeal spasm. Here the writer uses a thick paste of **alum**, starch, water, and a little glycerin applied freely to the tube, which is then allowed to dry a few hours and inserted. The alum acts very satisfactorily on the ulcerations. The alum coated tube is recommended whenever intubation exceeds 150 hours or the tube upon removal shows black or white spots indicative of ulceration. H. Mallet (*Revue médicale de la Suisse romande*, Aug., 1915).

Intralaryngeal medication in cases of *recurring stenosis* has been warmly advocated. Many observers have used the intubation tube itself with advantage as a carrier of local remedies. Thus, Fischer, for a child 2 years old, has a 1-year-sized tube coated with a jelly made up of shredded French **gelatin and glycerin**, of each, 2 parts; **ichthyol**, 1 part, and water, 10 parts. This is melted on a water-bath, and the tube dipped into it and allowed to dry. Excess of gelatin coating can be made to drip off by steaming the tube.

Case of a female patient who had been wearing an adult intubation tube continuously for nine months. One year before, she had been trache-

otomized for impending suffocation. Examination later showed the larynx to be practically closed. Under chloroform, a hard-rubber intubation tube was substituted for the tracheotomy tube. The tracheotomy wound healed well, excepting a small sinus, which necessitated closing by operation. The tube was then worn constantly, with perfect comfort. W. K. Simpson (*Laryngoscope*, Jan., 1904).

Stenosis of the larynx after secondary tracheotomy following intubation can be prevented by not allowing the larynx to be excluded from the respiration a moment longer than absolutely necessary. The stenosis is due mainly to the lack of normal participation in the breathing act. H. v. Ranke (*Münch. med. Woch.*, Bd. lii, Nu. 42, 1905).

Case of postoperative perichondritis of the larynx in which, for the increasing dyspnea, tracheotomy was required. Gradual dilatation with Schrötter's tubes was practised for about a month, followed by intubation under chloroform, the tube being worn for six weeks. Reintubation eight days later for increasing dyspnea. The tube was then retained for three months continuously, during all of which time the patient swallowed food well. She was then extubated, but twelve hours later dyspnea ensued, requiring reintubation with a small metal tube. Three weeks later the tube was removed permanently. The case was thus entirely cured by intubation.

In another case, with papilloma of the larynx, operation was followed by tracheotomy, and, later, unsuccessful attempts were made to have the patient wear a large-sized hard-rubber intubation tube, which was soon coughed out. Finally, a metal intubation tube with the Rogers attachment (a screw-piece attachment introduced through the tracheotomy wound) was introduced, and this was kept in position for four weeks. Some small pieces of granulation tissue were removed endolaryngeally, and

the patient was discharged as cured, with a hoarse, but fairly loud, voice. Emil Mayer (Med. Rec., Dec. 25, 1909).

MODIFICATIONS OF O'DWYER'S INSTRUMENTS.—The instruments, as fully perfected by O'Dwyer, have been modified by various operators; some of these modifications are questionable improvements, while some undoubtedly

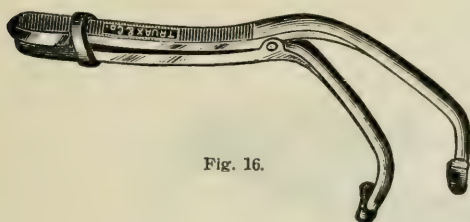


Fig. 16.

possess advantages. The main idea, however, remains unchanged, and, however greatly the instruments may be altered, the fame of the original inventor will never be dimmed. In this connection reference will be made to only a few of these modifications.

One of the writers (Waxham), in the early history of the operation, finding the original gag (Fig. 16) inconvenient on account of its striking the shoulder, had one constructed (Fig. 18) to extend backward instead of downward, thus overcoming this objection. This gag answers well all requirements. The gag has also been modified by others, notably by Henrotin (Fig. 17) and Allingham (Fig. 19). An ingenious method of overcoming the difficulty of extracting the tube was devised by Dillon Brown. It consists of a tube, with small ring attached to the head, and a thimble, with hook attached, which he used on the index finger of the right hand. Another modification has been devised by Ferroud, aiming to make one

instrument answer for both extractor and introducer; his instruments have been still further modified and simplified.

A number of years ago, one of the writers (Waxham) devised a set of instruments differing in many particulars from those of O'Dwyer, the dominant idea, however, being the same. The aim was to insure more perfect disinfection. The obturator has no joint and is not screwed upon the instrument, but is a plain band of steel solidly attached to the introducer. Moreover, the instrument, which consists of only two plain pieces of metal, can be easily separated. There are no crevices in which septic matter can be concealed. The tubes are the same as in the O'Dwyer set. The gag is constructed so as to insure unlocking of the blades for purposes of disinfection. The ex-

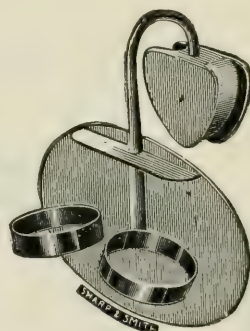


Fig. 17.

tractor (Fig. 20) is also so constructed that the three parts of which it is made can easily be separated for the same purpose. These instruments are simple and efficient.

Thorner has designed an instrument which combines the offices of extractor and introducer. It has at its distal extremity two serrated beaks about 2 inches long (Fig. 21). They

are opened by pressure with the thumb upon a lever, and are automatically held open by a ratchet arrangement, while pressure with the index finger upon the lower end of this ratchet-bar relieves it and closes

clining from right to left. This facilitates the passage of the tube between the vocal cords.

COMPARATIVE VALUE OF INTUBATION.—The weight of evidence in favor of intubation, as com-

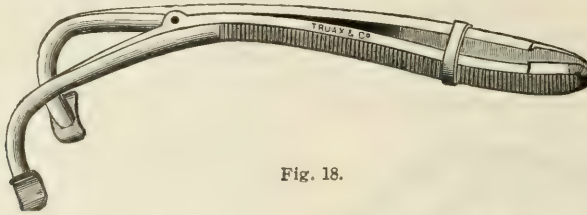


Fig. 18.

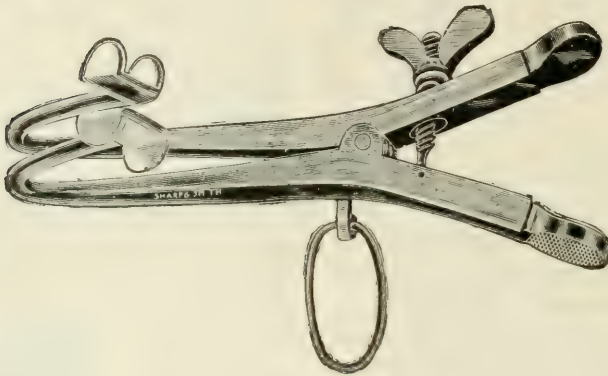


Fig. 19.

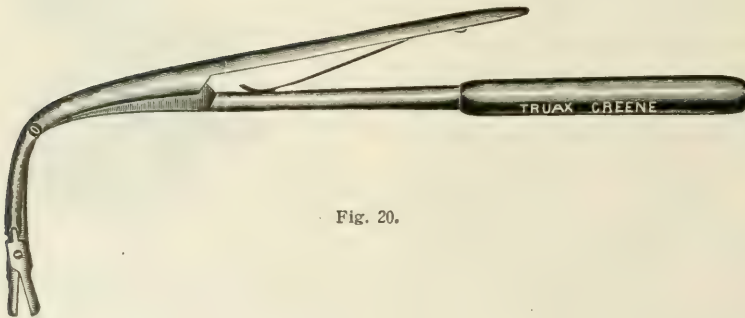


Fig. 20.

the beaks. By firm pressure the beaks hold the tube immovably. The tubes themselves are also slightly modified, the upper opening being funnel-shaped to facilitate the introduction of the beaks when the tube is in the larynx, and the lower end being cut off at an angle of 45 degrees, in-

pared to that favoring tracheotomy, leaves the advantage with intubation as a life-saving operation. Out of 543 cases in which one of the authors performed intubation, all in private practice, he obtained 215 recoveries, or 39.79 per cent. In the last series of 143 cases, there were 76 recoveries, or

53.14 per cent. In 40 cases in which antitoxin was employed in conjunction with intubation, there were 38 recoveries, or 95 per cent. Of 410 cases intubated at the Willard Parker Hospital, New York, in 1904, 47 per cent. recovered.

Of 437 intubations for laryngeal diphtheria, in 80 per cent. the patients

tonsils are prominent predisposing factors in diphtheritic infections of the larynx. Laryngeal paralysis is extremely rare after intubation. Scar tissue was observed in two cases. Shurly (*Annals of Otol., Rhin., and Laryn.*, Dec., 1910).

If a patient dies after intubation from bronchial obstruction due to the presence of diphtheritic exudation,

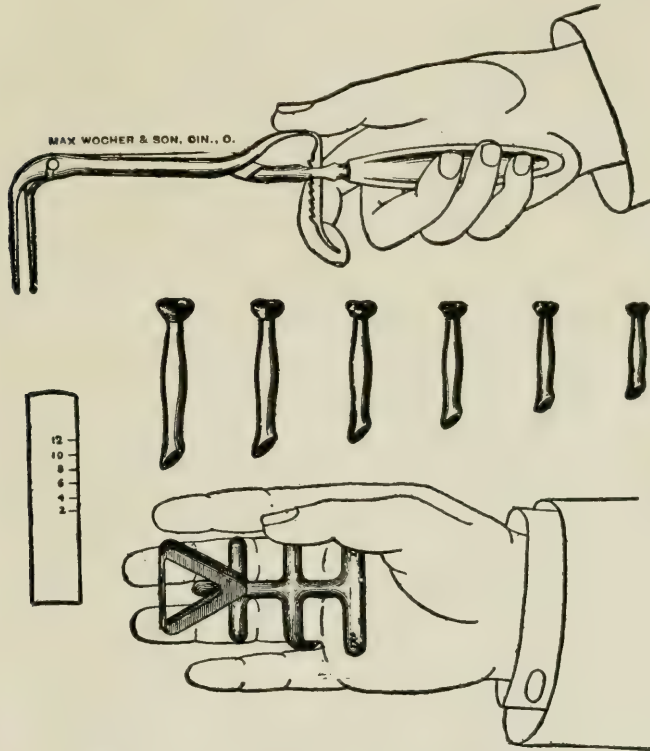


Fig. 21.—Thorner's combined introducer and extractor.

were alive when the tube was removed. Among 30 of the older children subsequently examined, the time during which the tube had been worn consecutively was from forty-eight hours to one hundred and twenty-four hours. The author concludes that intubation in laryngeal diphtheria is required more frequently when marked tonsillar hypertrophy exists, and that pathological adenoids and

antitoxin has either been used late, the extension having taken place before its administration, or has been used with a hesitating hand and in insufficient dosage.

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